MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

.93d

1261

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Eleven years

Hospital, institution, or street address where death occurred:

330 Highland Drive

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 330 Highland Drive

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Lillian Bertha Anthony

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife George A. Anthony

6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) 3-29-1874

8. AGE:

Years	Months	Days	If less than one day
74	8	18	... hrs. ... min.

9. Birthplace Lincoln, R. I.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

FATHER

12. Name Nicholas H. Easton

13. Birthplace — R.I.

MOTHER

14. Maiden name Mary Ella Jenks

15. Birthplace — R.I.

16. Informant George A. Anthony

Address 330 Highland Drive

17. CREMATION (Burial, cremation, or removal. Which?) Date thereof 12-20-48 (month) (day) (year)

Cemetery or crematory FT. LINCOLN CREMETORY

Location PR. GEO. CO., MD.

18. Funeral director S. H. Hines Co.

Address 2901-14th St., N.W. Washington, D.C.

19. 12-17 19 48 (Date rec'd by registrar) W E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1948 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1, 1946 to Dec 17, 1948 and that I last saw h. alive on Dec. 16, 1948

	DURATION
Immediate cause of death Cerebral embolism.	1 day.
Due to Hypertensive heart disease with auricular fibrillation.	4 years
Due to —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Frank S Bacon M.D.

M. D. or other

Address 1150 Conn. Ave. Date signed 12-17-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

12612

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
108 Cedar Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Takoma Park, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 108 Cedar Ave.
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: NANNIE ELIZABETH ARMENTROUT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife: Edwin R. Armentrout

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 29, 1860

8. AGE:

Years	Months	Days	If less than one day
88			hrs. min.

9. Birthplace: Rock Bridge Co., Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William Alexander Hull
13. Birthplace: Rock Bridge Co. Va

MOTHER
14. Maiden name: Margaret Reich
15. Birthplace: Rock Bridge Co., Va.

16. Informant: Russell Armentrout - Son
Address: 108 - Cedar Ave, Takoma Pk, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan - 1949 (month) (day) (year)

Cemetery or crematory: Thornrose Cemet

Location: Staunton Va

18. Funeral director: Harry L Shye

Address: 1009 H St NW Washington DC

19. Dec 29 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29, 1948, at 3:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 (approx) to Dec 29 1948, and that I last saw her alive on Dec. 28 1948

Immediate cause of death		DURATION
	Cerebral apoplexy	4 days
Due to	Hypertension, arterial	Chronic
Due to	Arteriosclerosis	Chronic
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: P. M. Nichols M.D.
M. D. or other

Address: 2200 - 19th NW. Wash. D.C. Date signed: 12/29/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

12613

460

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ Months

Hospital, institution, or street address where death occurred: 4816 Middlesex Lane, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4816 Middlesex Lane
(If rural, give LOCATION)

2.(a) If veteran, name war: World War #1

3. (a) FULL NAME: HORACE POWERS BANNON

3. (b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie Grace Bannon

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.): Aug. 10th 1889

8. AGE:	Years	Months	Days	If less than one day
59	59	5	18	...... hrs. ...... min.

9. Birthplace: Macon, Ga.
(Town, county, and state)

10. Usual occupation: Commerce - Business Specialist

11. Industry or business: For Government

FATHER
12. Name: John Charles Bannon
13. Birthplace: Conn.

MOTHER
14. Maiden name: Emma Powers
15. Birthplace: Atlanta, Ga.

16. Informant: Elsie Grace Bannon

Address: 4816 Middlesex Lane, Bethesda

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 31, 1948 (month) (day) (year)

Cemetery or crematory: Arlington Nat. Cemetery

Location: Arlington, Virginia

18. Funeral director: Wm Reuben Pumphrey Funeral Home

Address: Bethesda, Md.

19. 12/28 1948 W. E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28, 1948, at 4:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. '45 19.., to Dec. 28 1948, and that I last saw him alive on 12/28/48 19..

Immediate cause of death	DURATION
Inanition	
Due to: Carcinoma of esophagus	1 yr.
Due to	

Other conditions: (1) Essential hypertension (2) Hypertensive heart disease
(Include pregnancy within 3 months of death)

Major findings of operations: .... Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury .... Injured at work?

23. Signature: Bernard J. Walsh M.D. M. D. or other

Address: Vanguard Bldg, Wash. D.C. Date signed: 12/28/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45.15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12614

163M

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Years

Hospital, institution, or street address where death occurred:
907 Goldsbora Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 907 Goldsbora Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME John H. Barron

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ruth Story Barron

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): Nov. 16th 1900

8. AGE: Years	Months	Days	If less than one day
48	0	17	hrs. min.

9. Birthplace: Baltimore, Ohio
(Town, county, and state)

10. Usual occupation: Radio Eng. Own Business

11. Industry or business

FATHER — 12. Name: John H. Barron, Sr.
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Anna Browning
15. Birthplace: Maryland

16. Informant: Ruth Story Barron
Address: 907 Goldsboro Rd., Bethesda, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Dec 6 48 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Washington, D.C.

18. Funeral director: Wm Reuben Pumphrey.

Address: 7557 Wisconsin Ave., Bethesda

19. 12-4 1948 (Date rec'd by registrar) W.C. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 3 1948 at ? P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dep Med Exam case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxia	Found dead in car.
Due to Monoxide gas (Suicide)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of 12-3-48
Where did injury occur? Bethesda (City or town) Mont (County) Md (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Joseph J. Bernhart M.D. Dep med Exam. M. D. or other
Address Gaithersburg Md Date signed 12-4-48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12615

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 e

Reg. Dist. No. 215

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 1 day

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: M D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Gordon Hotel, 16th & K St., N. W.
(If rurol, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: BARTLETT, Mabel Rainey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 22, 1884

8. AGE: Years	Months	Days	If less than one day
64	9	28	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business:

FATHER
12. Name: RAINEY, Francis
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: McELFRESH, Francis
15. Birthplace: Pa.

16. Informant: sister: Mrs. Frances R. Stone
Address: 4807 Hampden Lane, Bethesda, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-23-48 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Washington, D. C.

18. Funeral director: Reuben Pumphrey per J. J. Riley

Address: 7557 Wisconsin Ave., Bethesda, Md.

19. 12-20- 19 48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 December 19 48 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 October 19 48 to 20 December 19 48 and that I last saw h[illegible] alive on 20 December 19 48

Immediate cause of death	DURATION
Carcinoma sigmoid, metastatic	12 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma sigmoid with peritoneal metastasis Date of op. Jan. 48

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. J. ZUSKA, Cdr. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed 12-20-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

12616

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

206 Holly Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 206 Holly Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME MISS MARY HOWARD BAYLY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 27, 1870

8. AGE:

Years	Months	Days	If less than one day
78	1	7	..... hrs. ..... min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Retired Civil Service Examiner

11. Industry or business: U.S. Government

FATHER

12. Name: Charles B. Bayly

13. Birthplace: Washington, D.C.

MOTHER

14. Maiden name: Mary Howard

15. Birthplace: Washington, D.C

16. Informant: Mrs. Gertrude De Witt

Address: 2920 Ontario Rd. NW. Washington, DC

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 6, 1948 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Rock Creek Ch. Rd. & Webster Sts. NW.

18. Funeral director: J. Archer Walters

Address: 234 Carroll St. Takoma Park, D.C.

19. Dec 4 1948 (Date rec'd by registrar) J. Nelson Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 4 1948, at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1948, to Dec 4 1948, and that I last saw her alive on Dec 4 1948.

	DURATION
Immediate cause of death: Acute Coronary thrombosis	12 hours
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arthur E Cogan M.D. M. D. or other

Address: Washington Sanitarium & Hospital Date signed: Dec 4 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92d

12617

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Montgomery

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 240
(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME HENRY THOMAS BEAN

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Georgeanna Bean (Dec)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 25th 1868

8. AGE: Years	Months	Days	If less than one day
80	3	4	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name James W. Bean

13. Birthplace Maryland

MOTHER 14. Maiden name Margaret Mitchell Bean

15. Birthplace Washington, D.C.

16. Informant Mrs. Margaret Elliott

Address 137 Broadway, Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/31/48 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Wm. Reuben Pumphrey Funeral Home

Address 7557 Wisconsin Ave., Bethesda Md.

19. 12-31 1948 T. P. Thompson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 19 48 at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep med Exam Case 19 ..... to ..... 19 .....

and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
Chronic Valvular heart disease	1 yr.
Due to Acute cardiac dilatation	1 hr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Bouchart M.D. Dep med Exam M. D. or other

Address Hagerstown Md Date signed 12-30-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15M

EVIDENCE FOR CHANGE OF MOTHER'S NAME SHOWN ON:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12618

9384

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
10,000 Georgia Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Couety

City or town Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1112 - 16th St., N. W. Apt. 201
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James N. Bell, Sr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife Clara Vanderburg

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1869

8. AGE: Years	Months	Days	If less than one day
79	5	20	hrs. min.

9. Birthplace Norfolk, Va.
(Town, county, and state)

10. Usual occupation Chief Clerk City of Norfolk

11. Industry or business

FATHER
12. Name James N. Bell
13. Birthplace Virginia

MOTHER
14. Maiden name ~~Margaret~~ Hunter, Fannie
15. Birthplace Norfolk, Va.

16. Informant Miss Mildred V. Bell

Address 1112 - 16th St., N. W., Washington, DC

17. Removal Date thereof Dec. 28, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Norfolk, Norfolk Co., Va.

18. Funeral director Waxnax E. Humphreys

Address 8434 Ga. Ave., Silver Spring, Md.

19. Dec. 28 1948 Josephine M. Schaffe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1948 at 11:47 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 1948, to Dec. 27 1948 and that I last saw h.w.m. alive on Dec. 27 1948

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to Acute Myocarditis	
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Kenyon Lowden M.D.
M. D. or other

Address 1603 19th St. N.W. Date signed 12-27-48

VS A16 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46d 12619

Reg. Diat. No. 223-

1. PLACE OF DEATH:
County: Mont. Co.
City or town: Takoma Park, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Mont. Co.
City or town: Takoma Park Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 705 Greenwood Ave
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME: MARTHA BERNSTEIN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Samuel R
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 8/28/1893

8. AGE: Years	Months	Days	If less than one day
55			..... hrs. ..... min.

9. Birthplace: New York (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: MORRIS SCHNEIDER
13. Birthplace —

MOTHER
14. Maiden name: YETTA LOVENTHAL
15. Birthplace —

16. Informant: Nathan J. Bernstein
Address: 5324 - 2nd St. N.W. West D. C.

17. Burial, cremation, or removal. Which?: Removal — Date thereof: 12/26/48 (month) (day) (year)
Cemetery or crematory: Adas - Israel Cem
Location: Washington, D.C.

18. Funeral director: Goldberg Funeral Home
Address: 4217 - 9th St. N.W. Wash. D.C.

19. Dec 24 1948 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24, 1948 at 10 50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1948, to Dec 24 1948 and that I last saw her alive on Dec. 23, 1948

Immediate cause of death	DURATION
Cachexia (MALNUTRITION)	10 mo.
Due to: Carcinoma of the rectum	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Samuel A. Willman, M.D. (M. D. or other)
Address: 249 Missouri Ave NW Date signed: 12/24/48

M

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1245 12606

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1718 34th St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: BLATCHER, Arthur Clarence

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Elizabeth A. Blatcher

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 5, 1895

8. AGE: Years	Months	Days	If less than one day
53	5	3	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Dep. Marshal

11. Industry or business: D.C. Police Court

FATHER
12. Name: BLATCHER, William dec.
13. Birthplace: Eng.

MOTHER
14. Maiden name: BLACKETT, Clara dec.
15. Birthplace: Eng.

16. Informant: wife: Mrs. Elizabeth A. Blatcher
Address: 1718 34th St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12-10-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

19. Funeral director: S. H. HINES Robertson & Co

Address: 2901 14th St., N.W., Wash., D.C.

19. 12-8- 19 48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 December 19 48, at 1:06 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 30 November 19 48, to 8 December 19 48

and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
Cirrhosis, liver, Ateglace	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. A. DINSMORE, Jr., LCDR MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-8-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12607

52b

Reg. Diat. No. 215

M

I

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 2 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. [illegible]
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: BULMER, Anita Poor

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): September 16, 1883

8. AGE: Years	Months	Days	If less than one day
65	3	1	..... hrs. ..... min.

9. Birthplace: New York
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: POOR, Charles Hall dec.
13. Birthplace: N.Y.

MOTHER
14. Maiden name: LONGSTREET, Cornelia dec.
15. Birthplace: N.Y.

16. Informant: nephew: Mr. Richard L. Poor
Address: 781 N.E. 73rd St., Miami, Florida

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-20-48 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: Joseph Gawler Joseph Gawler Sons
Address: 1756 Penn. Ave, NW, Washington, D.C.

19. 12-18 1948 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 December 1948 at 10:18A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 November 1948 to 17 December 1948 and that I last saw h... im alive on 17 December 1948

Immediate cause of death	DURATION
Carcinoma bladder	1 yr?
Due to Pyonephrosis Bi. Ureteral	
Due to Pyelonephritis Bi. Ureteral	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: transitorial cell Ca. Bladder Grade II Date of op. 10/15/48 + 12/10/48

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. J. COKELY, Capt. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed 12-18-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

54a 12609 Reg. Dist. No. 215

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Rural, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mo 6 days
Hospital, institution, or street address where death occurred:
U S Naval Hospital
How long in hospital or institution? 7 mo 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural Route #1
(If rural, give LOCATION)
2.(a) If veteran, name war: Army W.W. 2

3. (a) FULL NAME: BURRISS, Hazel Joseph

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-3-09

8. AGE: Years	Months	Days	If less than one day
39	3	27	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Own

FATHER
12. Name: Hamilton Burriss
13. Birthplace: Maryland

MOTHER
14. Maiden name: Laura Frances Burriss
15. Birthplace: Maryland

16. Informant: Mother: Laura Frances Burris
Address: Route #1 Silver Spring, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-3-49 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington Virginia

18. Funeral director: Robert A. Pumphrey Robert A. Pumphrey
Address: 7557 Wisconsin Ave Bethesda, MD

19. 12-30-48 (Date rec'd by registrar) 19 Mary C. Patterson Registrar
Mary C. Patterson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 December 1948 at 550A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 May 1948, to 30 December 1948 and that I last saw him alive on 30 December 1948

Immediate cause of death	DURATION
Due to (Brain Tumor)	
Glioblastoma Multiforme	12 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Injured at work?
Means of injury

23. SIGNATURE: J.C. McNERNEY CDR MC USN
M. D. or other
Address: U S Naval Hospital Date signed: 12-30-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12610

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Rural, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo 8 days

Hospital, institution, or street address where death occurred:
U S Naval Hospital

How long in hospital or institution? 2 mo 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: PG

City or town: Brentwood
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3908 38th Street
(If rural, give LOCATION)

2.(a) If veteran, name war: Army W.W. I

3.(a) FULL NAME: CAHILLANE, Michael Joseph

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katherine Mary Cahillane

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 12-26-1886

8. AGE: Years	Months	Days	If less than one day
62	0	4	..... hrs. ..... min.

9. Birthplace: County Carey, Ireland (Town, county, and state)

10. Usual occupation: Govt Gaurd, Smithsonian Inst.

11. Industry or business: U S Govt

FATHER — 12. Name: Patrick Cahillane

13. Birthplace: Ireland Deceased

MOTHER — 14. Maiden name: Mary Cahillane

15. Birthplace: Ireland Deceased

16. Informant: Wife: Katherine Mary Cahillane

Address: 3908 38th St Brentwood, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 3, 1949 (month) (day) (year)

Cemetery or crematory: Calvary Cemetery

Location: Holyoke, Mass.

18. Funeral director: Timothy Hanlon L. E. G.

Address: 641 H Street NE Wash. D.C.

19. 12-30-48 (Date rec'd by registrar) 19..... Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 December 1948 at 910 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 October 1948 to 29 December 1948 and that I last saw him alive on 29 December 1948

Immediate cause of death	DURATION
Bronchogenic Carcinoma	
Due to	
Due to	
Other conditions: Arteriosclerotic Heart disease	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: D.E. Billman
D.E. BILLMAN LTJG MC
M. D. or other

Address: U S Naval Hospital Date signed: 12-30-48

EVIDENCE FOR ADDITIONAL INFO. ITEM # 21 SHOWN ON:

12620

MARYLAND STATE DEPARTMENT OF HEALTH

FILM No. G 118 JAN 21 1949 — 2411 N. Charles St., Baltimore — 99

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 4 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1679 35th St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI ✓

3. (a) FULL NAME: CANN, Samuel Adams

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 30, 1892

8. AGE: Years	Months	Days	If less than one day
56	5	16	hrs. min.

9. Birthplace: Georgia
(Town, county, and state)

10. Usual occupation: Lawyer

11. Industry or business:

FATHER — 12. Name: CANN, William G. dec.

13. Birthplace: Ga.

MOTHER — 14. Maiden name: ADAMS, Lavanie dec.

15. Birthplace: Ga.

16. Informant: son: Mr. Samuel A. Cann, Jr.

Address: c/o Wm. G. Cann 314 East 45th St., Savannah, Ga.

17. ~~burial~~ REMOVAL Date thereof 12-17-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Bonaventure Cemetery

Location: Savannah, Georgia

18. Funeral director: W. W. CHAMBERS

Address: 3072 M St., N.W., Wash., D.C.

19. 12-16 1948 Mary C. Patterson Mary G. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 December 1948, at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 November 1948, to 16 Dec. 1948 and that I last saw him alive on 16 December 1948

Immediate cause of death	DURATION
Due to: Coronary Artery Thrombosis	
Due to:	
Other conditions: Arteriosclerosis Obliterans	

(Include pregnancy within 3 months of death)

Major findings of operation: Right Lumbar Sympathectomy performed for arteriosclerosis obliterans 12/20/49 okay Date of op. 16 Dec 1948

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John C. McNerney, Cdr. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed 12-16-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

12621

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County MONTGOMERY
City or town CHEVY CHASE, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County MONTGOMERY
City or town CHEVY CHASE, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6508 MEADOW LANE
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: CLIFFORD P. CARPENTER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of wife: SARA JANE H. CARPENTER

7. Birth date of deceased (mo., day, yr.): Nov 16, 1883

6.(c) If alive, give age ..... years

8. AGE:

Years	Months	Days	If less than one day
65	0	15	..... hrs. ..... min.

9. Birthplace: WASHINGTON, D.C.
(Town, county, and state)

10. Usual occupation: RETIRED — GAS & ELECTRIC CO.

11. Industry or business

FATHER
12. Name: DR. JOHN EVANS CARPENTER
13. Birthplace: Ohio

MOTHER
14. Maiden name: RACHEL JOHNSTON
15. Birthplace: PENNSYLVANIA

16. Informant: MRS. SARA JANE H. CARPENTER
Address: 6508 MEADOW LANE, CHEVY CHASE, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 4, 1948 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Washington, D.C.

18. Funeral director: Joseph Gawler's Sons
Address: 1756 PENNA. AVE, NW, WASH. D.C.

19. 12/1 19 48 (Date rec'd by registrar) Wm E Gobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1, 1948 at 3.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 30 1948 to Dec. 1. 1948 and that I last saw him alive on Nov. 30 1948

Immediate cause of death	DURATION
Coronary Thrombosis	18 hours.
Due to arteriosclerosis	about 1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

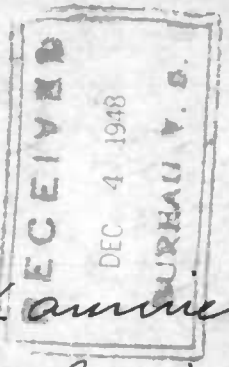
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Emmet T. Sappington M.D. M. D. or other
Address 1103-16th NW Date signed 12-1-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15



a medical Examiner
notified and will appear
Ernest T. Sappington M.D.

EVIDENCE FOR ADDITION IN #22 SHOWN ON:

12622

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILE No. G 113 JAN 25 1949 **CERTIFICATE OF DEATH**

Reg. Diat. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. Brighton Hotel, 2123 Calif. St., N.W.
(If rurol, give LOCATION)

2.(a) If veteran, name war: WWII

3.(a) FULL NAME

CARPENTER, William Hubbard

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Josephine Carpenter

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 29, 1904

8. AGE: Years	Months	Days	If less than one day
44	10	5	..... hrs. ..... min.

9. Birthplace: New York
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business

FATHER
12. Name: CARPENTER, William dec.
13. Birthplace: New York

MOTHER
14. Maiden name: HUBBARD, Christine
15. Birthplace: N.Y.

16. Informant: wife: Mrs. Josephine Carpenter
Address: Brighton Hotel, 2123 Calif. St., N.W. Washington, D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-9-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: W.W. CHAMBERS FUNERAL HOME

Address: 1400 Chapin St. N.W., Wash. D.C.

19. 12-4- 19 48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 December 1948 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 1 1948 to 4 December 1948 and that I last saw him alive on 4 Decmeber 1948

Immediate cause of death	DURATION
Air Emboli a	Instant
Cerebral and Cardiac	
Due to: Pneumothorax, Left	6 days
Due to: Fracture, Left 10th Rib	
Other conditions: Atelectasis, Complete left lung. Emphysema, right lung.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Fall Date of Nov 29, 1948
Where did injury occur? Washington (City or town) (County) D.C. (State)
Injured at home, farm, industry, public place (where?) Apartment, Brighton Hotel
Nature of injury: Fell in bathroom striking head Injured at work? Commander [1/25/49 abc]

23. SIGNATURE: R. M. Dixon, Jr. MC USN
M. D. or other

Address: US NH Bethesda, Md. Date signed 12-4-48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

16060 12608

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution? One Month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: District of Columbia
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5914 16th ST., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Cassel, Mr. Roy L

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 9, 1893

8. AGE: Years	Months	Days	If less than one day
55 yrs	1 mo	11 da.	hrs. min.

9. Birthplace: Seattle, Wash.
(Town, county, and state)

10. Usual occupation: Real estate Broker

11. Industry or business:

FATHER
12. Name: Elmer F. Cassel
13. Birthplace: Ill.

MOTHER
14. Maiden name: Vinnie M. Latimer
15. Birthplace: Galesburg, Ill.

16. Informant: R. D. Evans (friend)

Address: Same

17. (Burial, cremation, or removal. Which?) Date thereof: 12-22-48 (month) (day) (year)

Cemetery or crematory: Cremation

Location: Cedar Hill Pr. Geo. Co

18. Funeral director: Wintermans Funeral Home

Address: 5732 Georgia Ave. N.W. Wash. D.C.

19. 12-21-48 W.E. Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 20, 1948, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 23, 1948 to Dec 20 1948 and that I last saw him alive on Dec 20, 1948

Immediate cause of death	DURATION
Chronic Cardio-Vascular Degenerative Disease	8 yrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Emil G. Bauerfeind M.D.
M. D. or other

Address: Bethesda, Md. Date signed: 12/20/48.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12623

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9510 Old Bladensburg Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lillian M. Chestnut

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Samuel G. Chestnut
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 30, 1882

8. AGE: Years: 66 Months: Days: If less than one day: hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: William Bannister
13. Birthplace: Wash D.C.
MOTHER 14. Maiden name: Mary Allen
15. Birthplace: Va
16. Informant: Samuel G. Chestnut
Address: 9510 Old Bladensburg Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 10 1948 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md.
18. Funeral director: Deal Funeral Home
Address: 4812 Georgia ave NW
19. Dec 8 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8 1948 at 5:30A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 1946 to Dec 8 1948 and that I last saw h.e.r alive on Dec. 7 1948

Immediate cause of death	DURATION
Acute Dilatation of Heart	10 min
Due to: Coronary Thrombosis	2 years
Due to: Generalized Arteriosclerosis	6 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W B Wardley MD M. D. or other
Address: 837 Bonifant St Silver Spring, Md Date signed: 12/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12624

6

Reg. Diat. No. 217

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Montgomery

City or town OLNEY
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital Inc.

How long in hospital or institution? 45 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Germantown
(If outside city or town limits, write RURAL and give nearest town)

Street No. R # 1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Kenneth Lee Childs

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 18 1945

8. AGE: Years 3 | Months 7 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace OLNEY Montgomery Maryland
(Town, county, and state)

10. Usual occupation Child

11. Industry or business

FATHER

12. Name Fielder Bowie Childs

13. Birthplace Laytonsville Maryland

MOTHER

14. Maiden name Elsie Gladys (Whetzel)

15. Birthplace Manassas, Virginia

16. Interment Hospital Records

Address

17. Burial Date thereof Dec 8 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Laytonsville MD

Location Montgomery Co MD

18. Funeral director Roy W. Barber

Address Laytonsville, Md.

19. 12/8 1948 Gertrude B Fowler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6/48 19 ..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12 noon 12/6/ 1948, to 12:45 PM 19 1948
and that I last saw him alive on 12/7 19 48

Immediate cause of death	DURATION
meningococcus septicemia	
Due to adrenal hemorrhage shock	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md. Date signed 12/6/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

Co 13625

Reg. Dist. No. 129

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months - 12 days.

Hospital, institution, or street address where death occurred:

Washington San + Hospital

How long in hospital or institution? 5 months - 12 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District Columbia County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 712 - 5th st. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Leonard Henry Davis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-3-1878

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	3	15		

9. Birthplace: England - London (Town, county, and state)

10. Usual occupation: Elevator Inspector

11. Industry or business: Westinghouse Corp.

FATHER

12. Name: Roger J. Davis II

13. Birthplace: England

MOTHER

14. Maiden name: Elizabeth Armstrong

15. Birthplace: England.

16. Informant: Parent's chart.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24 1948 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Washington D.C.

18. Funeral director: West End Home Co.

Address: 300 - 9th St. S.E.

19. DEC 24 1948 (Date rec'd by registrar) J. Woodall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 21 1948 at 9:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1948 to Dec 21 1948 and that I last saw h alive on Dec 20 1948

	DURATION
Immediate cause of death: Coronary Thrombosis	
Due to: Hypertensive Cardiovascular Renal Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: DeVoe K. Muse M.D. M. D. or other

Address: Takoma Park Md. Date signed: 12-21-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1948-12-21
20-3-18
1948-9-3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12626

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Rural, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 days
Hospital, institution, or street address where death occurred:
U.S.Naval Hospital
How long in hospital or institution? 35 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Distt. Columbia County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1246 10th St N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war World War 11

3.(a) FULL NAME DAVIS, View McFranklin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife Mary Lee Davis
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-17-04

8. AGE: Years	Months	Days	If less than one day
44	8	0	..... hrs. ..... min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual occupation Clerk Veterans Administration
11. Industry or business
FATHER 12. Name Robert Davis
13. Birthplace South Carolina deceased
MOTHER 14. Maiden name Tance Anthony
15. Birthplace South Carolina deceased
16. Informant Wife: Mary Lee Davis
Address 1246 10th St NW, Washington, D.C.
17. Burial Removal (Burial, cremation, or removal. Which?) Date thereof Dec. 21, 1948 (month) (day) (year)
Cemetery or crematory Muldrow Cemetery
Location Sumter, South Carolina
18. Funeral director W.Ernest Jarvis
Address 1432 U St NW Washington D.C.
19. 12-19- 1948 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 December 1948 at 6:40P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 November 1948 to 17, December 1948 and that I last saw him alive on 17 December 1948

	DURATION
Immediate cause of death Intestinal Obstruction, Burial	40 days
Due to Tuberculous Peritonitis	2 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Tuberculous Peritonitis, multiple adhesions Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE John W. Flynn J.W.FLYNN LTJG MC USN M. D. or other
Address U.S.Naval Hospital Date signed 12-19-48

12627

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

76d

CERTIFICATE OF DEATH

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or Institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4505 Gladwyne Drive
(If rurel, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: DEAN, Edith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Henry T. Dean, Lt. MSC USN

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 12, 1892

8. AGE: Years	Months	Days	If less than one day
56	2	15	..... hrs. ..... min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: (ex Navy Nurse)

MOTHER FATHER

12. Name: HEBDEN, George dec.

13. Birthplace: England

14. Maiden name: NICHOLS, Rebecca dec.

15. Birthplace: England

16. Informant: Husband: Lt. Henry T. Dean MSC USN

Address: 4505 Gladwyne Dr., Bethesda, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-30-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: W. W. Chambers N.A.C.

Address: Georgetown, D.C.

19. 12-28- 1948 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 December 1948 at 7:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 December 1948 to 27 December 1948 and that I last saw her alive on 27 December 1948

Immediate cause of death	DURATION
Myocardial Infarction	16d.
Due to: Hypertensive C.V. Disease	?
Due to: Azotemia	10d.
Other conditions: Pericarditis	4d.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. M. Spaulding E. M. SPAULDING, Cdr. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed 12-28-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

468

12628

Reg. Dist. No. 2/3

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Weeks

Hospital, institution, or street address where death occurred:
Woodland Dr.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Woodland Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

ANGELINE M. DeFREYTAS

3.(b) Social Security Number
011-01-2718

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John E. DeFreytas

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Dec. 4, 1894

8. AGE: Years	Months	Days	If less than one day
54	0	22	... hrs. ... min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual occupation: Gown designer

11. Industry or business: Dress Making

MOTHER FATHER

12. Name: ? Chinetti

13. Birthplace: Italy

MOTHER

14. Maiden name: Unknown

15. Birthplace: Italy

16. Informant: Charles M. DeFreytas

Address: Rockville, Maryland

17. Burial Transit
(Burial, cremation, or removal. Which?)

Date thereof: Dec. 27, 1948
(month) (day) (year)

Cemetery or crematory

Location: Boston, Mass.

18. Funeral director: Wm. Reuben Pumphrey Funeral Home

Address: Bethesda, Maryland

19. 12-27 1948 (Mrs.) E R Thompson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26 1948, at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 25? 1948, to December 26 1948

and that I last saw her alive on December 26 1948

Immediate cause of death	DURATION
CARCINOMA OF STOMACH	1 yr. approx.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Edith E. DeFoster, M.D.
M. D. or other

Address: 4648 East-West Hway Bethesda 14, Md. Date signed: 12/26/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

838

12629

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: KENWOOD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 YEARS

Hospital, Institution, or street address where death occurred: 107 HIGHLAND DRIVE.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: KENWOOD MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 HIGHLAND DR.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: MRS. JESSIE N. DIGGETT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SEPARATED

6.(b) Name of husband or wife: DR. ERNEST W. DIGGETT

6.(c) If alive, give age: UNKNOWN years

7. Birth date of deceased (mo., day, yr.): OCT. 19, 1874

8. AGE: Years: 74 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: LEWISBURG, PENNA. (Town, county, and state)

10. Usual occupation: AT HOME

11. Industry or business:

FATHER
12. Name: DAVID MONTGOMERY NESBIT
13. Birthplace: LEWISBURG, PENNA.

MOTHER
14. Maiden name: NANCY THORPE
15. Birthplace: PENNA.

16. Informant: MRS. DOROTHY D. BRAWNER
Address: 107 HIGHLAND DR, KENWOOD, MD.

17. CREMATION (Burial, cremation, or removal. Which?) Date thereof: DEC 29 1948 (month) (day) (year)

Cemetery or crematory: CEDAR HILL

Location: SUITLAND, MD.

16. Funeral director: Jas. Gawler & Sons

Address: 1706 Pa. Ave. N.W. Wash. D.C.

19. 12-29 1948 (Date rec'd by registrar) M. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-27 1948 at 11 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-12 1948 to 12-27 1948 and that I last saw h[illegible]ative on 12-27 1948

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to: Hypertension	13 Yrs.
Due to: Arteriosclerosis	12
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Geo. R. Hoffman M.D.
M. D. or other

Address: 117 Hatton Rd. Kenwood Md. Date signed: 12/28/48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7 MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Battimore

CERTIFICATE OF DEATH

73d 12630

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route #1, Box 196
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME

DREIFUS, Harry

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 25, 1894

8. AGE: Years	Months	Days	If less than one day
54	10	21	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Guard

11. Industry or business: US Government

FATHER — 12. Name: DREIFUS, Samuel dec.

FATHER — 13. Birthplace: Va.

MOTHER — 14. Maiden name: HECHT, Eva

MOTHER — 15. Birthplace: Wash., D.C.

16. Informant: sister: Mrs. Helen D. Roth

Address: Rt. #1, Box 196, Silver Spring, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-20-48 (month) (day) (year)

Cemetery or crematory: Ivy Hills

Location: Alexandria, Va.

Francis J. Collins

18. Funeral director: Francis J. Collins, J.C.

Address: 3821 14th St., N. W., Wash., D.C.

19. 12-16- 19 48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 December 19 48, at 2:13 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7 December 19 48, to 16 December 19 48 and that I last saw him alive on 16 December 19 48

Immediate cause of death	DURATION
Hypertensive Heart Disease	2 yrs
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

W. F. Queen

23. SIGNATURE: W. F. QUEEN, Comdr. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed 12-16-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12631

93d

Reg. Diat. No. 218

1. PLACE OF DEATH:

County: Montgomery

City or town: Boyds

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all his life

Hospital, Institution, or street address where death occurred: Home

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Boyds

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ADDISON EUGENE DUFFIN

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	

B.(b) Name of husband or wife: Anna Cecilia Duffin

6.(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): August 21, 1869

8. AGE: Years: 89 | Months: 3 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Boyds Montgomery Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: "

FATHER — 12. Name: Henry Duffin

13. Birthplace: Montgomery County Maryland

MOTHER — 14. Maiden name: Maria Hackett

15. Birthplace: Montgomery County Maryland

16. Informant: Edna Duffin

Address: Daughter

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/15/48 (month) (day) (year)

Cemetery or crematory: Boyds Cemetery

Location: Boyds Md.

18. Funeral director: Joseph B. Tschiffely

Address: Gaithersburg Md.

19. Dec 13 1948 (Date rec'd by registrar) Edna L. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 December 1948 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 May 1948 to 12 December 48 and that I last saw h... alive on 12 December 1948

Immediate cause of death	DURATION
Congestive heart failure	12 hours
Due to: Coronary occlusion	2 days
Due to: Arteriosclerosis	? years
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none — Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: John S. Fawcett M.D.
M. D. or other

Address: P.O. Boyds, Md. Date signed: 13 Dec 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

160a

12632

Reg. Dist. No. 215

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Rural, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred:
U.S.Naval Hospital.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Dist.of Columbia County
City or town Washington,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4301 S.Capitol Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
FRENCH, Karen Marie

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	SINGLE

6.(b) Name of husband or wife [illegible]
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-8-48

8. AGE: Years	Months	Days	If less than one day
0	0	2	hrs. min.

9. Birthplace Bethesda, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Malcolm L.French
13. Birthplace New Hamshire

MOTHER
14. Maiden name Wetoneah LaVonne French
15. Birthplace New Jersey

16. Informant Mother: Wetoneah LaVonne French
Address 4301 S.Capitol Street,Wash,DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-14-48 (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington Virginia

18. Funeral director W.W.Chambers
Address 517 11th St SE Washington,DC

19. 12-10-48 (Date rec'd by registrar) 19 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 December 19 48, at 5:57PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 December 1948, to 10 December 48 and that I last saw her alive on 10 December 1948

Immediate cause of death	DURATION
Immaturity	
Due to Cerebral Hemorrhage	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A.M.MARGILETH LTJG MC USN
M. D. or other
Address U.S.Naval Hospital Date signed 12-10-48

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94 a

12633

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 126 E. Bradley Lane

(If rurol, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME JOSEPH FREUND

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Marian C. Freund

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 13, 1879

8. AGE: Years	Months	Days	If less than one day
69	6	10	..... hrs. ..... min.

9. Birthplace Washington, D.C.

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Frederick Freund

13. Birthplace Washington, D.C.

MOTHER 14. Maiden name Elizabeth Drisch

15. Birthplace Unknown

16. Informant Wm. Ralph Freund

Address 516 A St. S.E., Washington, D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec. 24, 1948 (month) (day) (year)

Cemetery or crematory S.H. Hines Co.

Location 2901-14th St. N.W. Washington, D.C.

18 Funeral director Wm Reuben Pumphrey Funeral Home

Address Bethesda, Md.

19. 12-24 1948 W.E. Jobes

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 19 48 at 9:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 Med Exam 19 Case 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Fred J. Brockhurst M.D. M. D. or other

Address Dept Med Exam Gaithersburg Md Date signed 12-24-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12634

Reg. Diat. No. 216

1. PLACE OF DEATH

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Five days

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? Five days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: 1630 Argonne Pl. NW

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Washington DC

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: CARRIE M. GAINOR

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	

6.(b) Name of husband or wife: Edward J. Gainor

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov 14, 1870

8. AGE: Years	Months	Days	If less than one day
78			..... hrs. ..... min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: WILLIAM PASH

13. Birthplace: Ohio

MOTHER — 14. Maiden name: ANNA CONNORS

15. Birthplace: Ohio

16. Informant: Mr. Walter Dentz

Address: 1632 Argonne Pl. N.W. DC

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec. 18, 1948 (month) (day) (year)

Cemetery or crematory: Washington DC

Location: —

18. Funeral director: W Warren, Altamont

Address: 3619-14th St NW. DC

19. 12/18 1948 (Date rec'd by registrar) W. E. Johns Registrar

MEDICAL CERTIFICATION

645

20. DATE OF DEATH: Dec. 17 1948 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 1948 to Dec 17 1948 and that I last saw h... alive on Dec. 16 1948

Immediate cause of death	DURATION
Pulmonary Edema	48 hrs
due to Cardiac failure	
Due to Bronchial Pneumonia	6 days
Due to	
Other conditions Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: F. A. Mathews M. D. or other

Address: 4648 E-W. Hwy Date signed: Dec 17 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12635

94 ar

CERTIFICATE OF DEATH

Reg. Diat. No. 714

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: W.W. # 1

3.(a) FULL NAME: Russell B. Gill Russel B. Gill

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Wh.	Single

6.(b) Name of husband or wife: ----
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 2, 1893

8. AGE: Years	Months	Days	If less than one day
55	4	15	____ hrs. ____ min.

9. Birthplace: Silver Spring, Md. (Town, county, and state)
10. Usual occupation: Floor Sander
11. Industry or business

FATHER
12. Name: Levi C. Gill Sr.
13. Birthplace: Wash., D.C.

MOTHER
14. Maiden name: Augusta E. Wilson
15. Birthplace: Missouri

16. Informant: Mrs. Howard W. Niple
Address: Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 21, 1948 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: Warner E. Pumphrey Inc
Address: Silver Spring, Md.

19. Dec 20 19 48 (Date rec'd by registrar) Josephine V. Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 17 19 48 at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 17 19 48 to Dec 17 19 48
and that I last saw h alive on 19
Immediate cause of death: Coronary occlusion — DURATION: Few min
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bouchat M.D. M. D. or other
Address: Det Med Exam Gaithersburg Md Date signed 12-17-48

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

65e

12636

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Pine View Rest Home, River road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4710 Upton st. NW

(If rural, give LOCATION)

2.(a) If veteran, name war: no.

3. (a) FULL NAME JULIA GLASGOW

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Benjamin

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 13th 1880

8. AGE: Years: 68 Months: Days: If less than one day: hrs. min.

9. Birthplace: Beanpeast, Hungry (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Sigmund Fodar

13. Birthplace: Hungry

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Hungry

16. Informant: Mrs Alice J. Goldman

Address: 4710 Upton st. N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 1 1948 (month) (day) (year)

Cemetery or crematory: Mount Zion Cemetery

Location: Maspeth, N.Y.

18. Funeral director: H. H. Chambers Co.

Address: 1400 Chapin st. NW.

19. 12/1 19 48 (Date rec'd by registrar) W. E. Jalbert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Wed. Dec 1st 19 48 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 23 19 48 to December 1 19 48 and that I last saw h alive on November 30 19 48

Immediate cause of death	DURATION
Respiratory failure	
Due to: Pulmonary metastasis	
Due to: Generalized carcinomatosis (Primary site undetermined)	(Appx) 3 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert H. Loade M.D. M. D. or other

Address: 5702 Wisconsin Ave. Chevy Chase, Md. Date signed: 12/1/48

Evidence for correction of items 7, 8, & 12 shown on:

FILM NO. G 110 JAN 24 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

12637

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town 10000 Baltimore Silver Sp. Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 6 - weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10,000 Georgia Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lena Goldstein

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widow

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ~~1870~~ 1877

8. AGE — Years ~~71~~ ~~88~~ | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name Shepherd ~~Isaac~~ Goldstein
13. Birthplace Germany

MOTHER
14. Maiden name —
15. Birthplace Austria

16. Informant Charles Goldstein
Address 1344 - Underwood St N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 2 /49 (month) (day) (year)
Cemetery or crematory Adas Israel
Location Congress Heights
18. Funeral director B. Danzansky & Son
Address 3501 - 14th St. N.W.

19. Dec. 31 1948 (Date rec'd by registrar) per Irwin Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1948 at 5:02 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 24 1948, to Dec. 30 1948 and that I last saw him alive on Dec. 29 1948

Immediate cause of death	DURATION
Hypertensive heart disease	?
Due to Essential Hypertension	?
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Henry M. Lowden M.D.
M. D. or other
Address 1603 16th St. N.W. Date signed 12-30-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-5

CO. 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

77c

12638

Reg. Dist. No. 214

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

VS A15 9-45-15

1. PLACE OF DEATH:
County: Montgomery County
City or town: Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 hours
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 6hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4902 Third St. NW
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John Charles Grace

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Marguerite Brown deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 3, 1876

8. AGE: Years	Months	Days	If less than one day
72	8	28	..... hrs. ..... min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: retired (Govt.)
11. Industry or business:
FATHER 12. Name: Patrick Grace
13. Birthplace: Ireland
MOTHER 14. Maiden name: Anne Kennedy
15. Birthplace: Ireland or New Jersey
16. Informant: Cedarcroft Sanitarium
Address: Silver Spring, Md Jan 3, 1949
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/31/48 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Washington D.C.
18. Funeral director: James T. Ryan Inc
Address: 317 Pa ave S.E.
19. Dec 31 1948 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31 1948 at 3:50 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1948 to Dec 31 1948 and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral edema	
Due to Chronic glomerulonephritis acute (1/17/49-a.s.)	3 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Bosehart M.D.
Dep med. Examr M. D. or other
Address: Yanceyville N.C. Date signed 12-31-48

al. 1704

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12639

83a

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 hours

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 14 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Germantown Rt. 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Eva R. Griffith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or ~~wife~~: J. Cleveland Griffith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July, 24, 1875

8. AGE: Years 73 | Months 5 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace: Fairfax Co. Va.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Henry A. Spann

13. Birthplace: Montebello, Loudoun

MOTHER 14. Maiden name: Isabelle Lemmetyer

15. Birthplace: Westminster, Md.

16. Informant: Mrs. Ruth Pearlman

Address: Germantown Md. Rt. 2

17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof DEC. 30, 1948 (month) (day) (year)

Cemetery or crematory: Bethel

Location: ALEXANDRIA, VA.

18. Funeral director: CUNNINGHAM FUNERAL HOME

Address: 809 CAMERON ST. ALEXANDRIA, VA.

19. 12-30 19 48 W.E. Jobes

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30 1948 at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-28 1948, to 12-30 1948 and that I last saw h. ER alive on 12-30 1948

Immediate cause of death	DURATION
CEREBRO-VASCULAR HEMORRHAGE ON LEFT	2 DAYS
Due to: HYPERTENSION - LONG STANDING	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Jno W. Pearlman M.D

for Wm Welsh

M. D. or other

Address: Germantown Md. Rt. 2 Date signed 12-30-48

Rockville, Md

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12640

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

106

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution? 1 Day and 17 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Paalesville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Wilson Joshua Hamilton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Widowed

6.(b) Name of husband or wife Martha Hamilton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3 - 12 - 83

8. AGE: Years	Months	Days	If less than one day
65	8	29	..... hrs. ..... min.

9. Birthplace Paalesville Montg. Co. Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Dennis Hamilton

13. Birthplace Montgomery Co Md

MOTHER 14. Maiden name Martha Beckwith

15. Birthplace Montgomery Co. Md

16. Informant Henrietta Moore (Daughter)

Address Dickerson Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 14 1948 (month) (day) (year)

Cemetery or crematory Selmon Md

Location Poolesville Md

18. Funeral director Robert L. Lynch

Address Rockville Md

19. 12 - 14 1948 W E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1948, at 8 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 - 9 1948 to 12 - 11 1948

and that I last saw h. 1M alive on 12 - 11 1948

Immediate cause of death	DURATION
LOBAR PNEUMONIA	
BILATERAL	
Due to	
Due to	
Other conditions SCOLIOSIS & KYPHOSIS	
SLIGHT HYPERTROPHY OF HEART	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results LOBAR PNEUMONIA

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ira W. Pearlman M.D.
M. D. or other

Address Sulivan Hosp Bethesda, 14, Md. Date signed 12-12-48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

EVIDENCE FOR CHANGE OF AGE IS ON:

12641

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 118 JAN 26 1949 **CERTIFICATE OF DEATH**

Reg. Diat. No. 266

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6061- River Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Victoria - Hatton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Negro	Wid-

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 11, 1868

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
79 80	11	25		

9. Birthplace: Lawrence So. Car.

(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: David Hare

FATHER — 13. Birthplace: Clinton, S Car.

MOTHER — 14. Maiden name: ?

MOTHER — 15. Birthplace: ?

16. Informant: Mrs. Esther Whitehead

Address: 6061- River Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9, 1948 (month) (day) (year)

Cemetery or crematory: Lincoln mem.

Location

18. Funeral director: John T. Stewart

Address: 38- H St. N.E. Wash. D.C.

19. 12/6 1948 (Date rec'd by registrar) W. E. Jobe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-6 1948, at 3A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 1946 to Dec 6 1948

and that I last saw h[illegible] alive on 12-3 1948

Immediate cause of death	DURATION
Cardiac failure	?
Due to: Arteriosclerosis - Chr + parenchymatous nephritis	?
Due to:	
Other conditions: Bronchial asthma	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? —

23. SIGNATURE: Ogton D Simmons M. D. or other

Address: 1524 Yale Ave Date signed: 12-6-48

1524 U N.W.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

12642

Reg. Dist. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Clarksburg, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Clarksburg R.F.D. 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Columbus Hawse

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Gertrude Hawse
6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) April 16 - 1873

8. AGE:

Years	Months	Days	If less than one day
75	8	12	hrs. min.

9. Birthplace Lewisdale, Md, Montg Co.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Columbus Hawse
13. Birthplace Md
MOTHER 14. Maiden name Lucinda Moxley
15. Birthplace Md.
16. Informant Albert Hawse
Address Boyds, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/30/48 (month) (day) (year)
Cemetery or crematory Mt. View
Location Purdum
18. Funeral director William B. Hilton
Address Barnesville, Md
19. Dec. 29 1948 (Date rec'd by registrar) Mrs. C. C. Hilton By Mrs. W.B.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1948, at 2 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 1946, to Dec 28 1948
and that I last saw h. alive on Dec 27 1948

	DURATION
Immediate cause of death Cerebral Hemorrhage	2 days
Due to Arteria Sclerosis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ernest P. Roop M.D.
M. D. or other
Address New Market Md Date signed 12-28-48

EVIDENCE FOR ADDITIONAL INFO. ITEM #21 SHOWN BW.

FILM No. G 118 JAN 21 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 D

12643

Reg. Dist. No. 215

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Rural, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, Institution, or street address where death occurred:
U.S.Naval Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: P.G.
City or town: Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4415 41st Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3. (a) FULL NAME: HEATH, Henry, (n)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Aleene Heath
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 12-27-92

8. AGE: Years	Months	Days	If less than one day
55	11	13	____ hrs. ____ min.

9. Birthplace: Texas (Town, county, and state)
10. Usual occupation: Pipefitters helper
11. Industry or business: Naval Gun Factory

FATHER
12. Name: John Heath
13. Birthplace: Kentucky deceased

MOTHER
14. Maiden name: Elizebeth Stise
15. Birthplace: Kentucky deceased

16. Informant: Wife: Aleene Heath
Address: 4415 41st Street, Brentwood, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-15-48 (month) (day) (year)
Cemetery or crematory: National Memorial
Location: Falls Church, Virginia

18. Funeral director: W.W.Chambers Company
Address: 5801 Cleveland Ave, Riverdale, MD

19. 12-11-48 (Date rec'd by registrar) 19____ Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 December 1948, at 10:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December, 1, 1948 to December, 11, 1948 and that I last saw him alive on December, 11 1948

Cause	DURATION
Immediate cause of death: Broncho Pneumonia	2 days
Due to: gastric Obstruction	One Mos!
Due to: Carcinomatosis primary site - gastric [12/20/49 abc]	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: J.M. Hanner J.M.HANNER CDR MC USN M. D. or other
Address: U S Naval Hospital Date signed: 12-11-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-10M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

12644

Reg. Dist. No. 823-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 Days

Hospital, institution, or street address where death occurred:

Washington San. & Hospital

How long in hospital or institution? 19 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 Maple Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME DELLA MERRILL HEDGCOCK

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Dr. Geo. Leland Hedgcock deceased

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 26, 1872

8. AGE:

Years	Months	Days	If less than one day
76	4	18	..... hrs. ..... min.

9. Birthplace: Lincoln, Illinois (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Hiram Henry Merrill

13. Birthplace: Schenectady, New York

MOTHER

14. Maiden name: Margaret Dorcas

15. Birthplace: Leland, Illinois

16. Informant: Mr. Leland Hedgcock

Address: 512 Mississippi Ave. Silver Sp. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 16, 1948 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Bladensburg Rd. at District Line

18. Funeral director: J. Arthur Walters

Address: 254 Carroll St. NW Takoma Park, D.C.

19. Dec - 17 1948 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 14 1948 at 9:48 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-15 1947, to 12-14 1948

and that I last saw her alive on 12-14 1948

Immediate cause of death	DURATION
Acute Cardiac Failure	
Due to: Hypertensive Cardio-Renal Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Dean W. Harding M.D. M. D. or other

Address: 113 Carroll St NW Date signed: 12-14-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a 12645

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Mont.

City or town Westmoreland Hills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Mont.

City or town Westmoreland Hills

(If outside city or town limits, write RURAL and give nearest town)

Street No. # 13 Wetherill Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Louisa GORDON Hesse

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Henry A Hesse

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 24 - 69

8. AGE: Years	Months	Days	If less than one day
79	0	16	..... hrs. ..... min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name James Gordon

FATHER 13. Birthplace Philadelphia, Pa.

MOTHER 14. Maiden name Margaret Leitch

MOTHER 15. Birthplace Scotland

16. Informant Miss Marian E. Hesse

Address 13. Wetherill Rd, Westmoreland Hills

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-13-48 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location

18. Funeral director The D S Sines Co

Address 2901-14th St N.W. Wash D.C.

19. 12-10 19 48 W. E. Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Dec 1948 at 2 50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to 10 Dec 1948 and that I last saw h[illegible] alive on 4 Dec 1948

Immediate cause of death	DURATION
Acute Heart Failure	4 min
Due to Cerebral Hemorrhage	6 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Jane H Custer M. D. or other

Address 1852 Col Rd NW Date signed 12/10/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

82

12646

Reg. Dist. No. 2/6

1. PLACE OF DEATH:
County: Bethesda Montg.
City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3½ mos.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montg.
City or town: Route #3 Box 975
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bethesda Station
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM S. HOLLAND

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WID.

6.(b) Name of husband or wife: SARAH T. HOLLAND
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): SEPT. 26 1868

8. AGE: Years: 80 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: S.C.
(Town, county, and state)

10. Usual occupation: KEEPER AT ZOO

11. Industry or business

FATHER
12. Name: WILLIAM D. HOLLAND
13. Birthplace: S.C.

MOTHER
14. Maiden name: MARGARET SMITH
15. Birthplace: S.C.

16. Informant: CHRISTINE T. HOLLAND
Address: ROUTE #3, BETHESDA, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: DEC. 13 1948 (month) (day) (year)

Cemetery or crematory: POTOMAC
Location: MD.

18. Funeral director: W. W. CHAMBERS
Address: 3072 M ST. N.W.

19. 12/10 1948 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10 1948 at 12 00 Noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1948 to Dec 10 1948 and that I last saw h.i.y.r. alive on Dec 9 1948

Immediate cause of death	DURATION
Respiratory failure	
Due to Paralysis of respiratory muscles	
Due to For advanced cerebral arteriosclerosis & apoplexy	One year
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank Jaggen Jr. M. D. or other
Address: 5707 Wisconsin Ave Chevy Chase, Md. Date signed: 12/10/48

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136 12647

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Va. County:

City or town: Nokesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME HOLMES, Frank

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 22, 1895

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
53	3	0		

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: HOLMES, Arthur dec.

13. Birthplace: Va.

MOTHER — 14. Maiden name: BURGERS, Lilly dec.

15. Birthplace: Va.

16. Informant: brother: Mr. Clay Holmes

Address: Nokesville, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof Dec. 25, 1948 (month) (day) (year)

Cemetery or crematory: On own land

Location: Nokesville,, Va.

18. Funeral director: George D. Baker

Address: Manassas, Virginia

19. 12-22-48 x9 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 December 19 48 at 4:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 November 19 48, to 22 December 19 48.

and that I last saw him alive on 22 December 19 48.

Immediate cause of death	DURATION
Tuberculosis, renal bilateral	
Due to: Uremia	
Due to: Tuberculosis, larynx	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm. H. Miller Jr., Lt. MC USN M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-22-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-5

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12648

Reg. Diat. No. 1529

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred: Washington Sanitarium & Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Col. County:

City or town: Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1769 Church St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mrs Alexander Y. Johnson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs Isabel Johnson

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Dec. 4 1871

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
77	0	12		

9. Birthplace: Frederick, Maryland (Town, county, and state)

10. Usual occupation: Retired Broker

11. Industry or business:

FATHER 12. Name: Alex Johnson

13. Birthplace: Frederick, Maryland

MOTHER 14. Maiden name: Lucretia Read

15. Birthplace: Cumberland, Maryland

16. Informant: MRS ISABEL JOHNSON

Address: 17-9 CHURCH ST NW WASH

17. CREMATION (Burial, cremation, or removal. Which?) Date thereof: DEC 18 1948 (month) (day) (year)

Cemetery or crematory: CEDAR HILL CREMATORY

Location: SUITLAND, MARYLAND

18. Funeral director: Jos Gawler's Sons, Inc

Address: 1756 Pa Ave. N.W. D.C.

19. DEC 17 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16 1948 at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 to Dec 16 1948 and that I last saw h... alive on Dec 16 1948

Immediate cause of death	DURATION
a Intermittent Heart Disease	6-7 yrs.
Coronary Occlusion (Old)	
Due to: Hypostatic Pneumonia	4-5 days
Due to: Left ventricular failure	Sudden
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: 0

Date of op.

Autopsy results: 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Chas H. Holohan M.D.

M.D. or other

Address: 500 Underwood St NW Date signed: 12/16/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12649

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montg Co,

City or town: Gaithersburg Md,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18yr 2 Mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: GAITHERSBURG
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Adella Minnie Jones

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 2nd 1856

8. AGE: Years	Months	Days	If less than one day
1856- 92	1	9	..... hrs. ..... min.

9. Birthplace: Hillsboro. Va,
(Town, county, and state)

10. Usual occupation: House Keeping

11. Industry or business: " "

FATHER
12. Name: John Jones
13. Birthplace: Va,

MOTHER
14. Maiden name: Lydia Potts
15. Birthplace: Va,

16. Informant: Records Methodist Home
Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/14/48 (month) (day) (year)

Cemetery or crematory: Forest Oak Cemetery

Location: Gaithersburg. Md,

18. Funeral director: Ernest C. Gartner
Address: Gaithersburg .Md,

19. Dec 13 1948 (Date rec'd by registrar) Cloud L Poole Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 11th 1948 at 9.30PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov - 8 - 1948 to Dec - 11 - 1948 and that I last saw h[illegible] alive on Dec - 11 - 1948

Immediate cause of death	DURATION
Infirmities of Senility	10 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: William E. Fuller M.D. M. D. or other

Address: Gaithersburg, Md Date signed 12/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Keeley, Jessie Lane

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46d

12650

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery Co. Colesville Md.
City or town Colesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Mont.
City or town Colesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Same
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jessie L. Keeley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	wh	widow

6.(b) Name of husband or wife Rev. Hugh Keeley (deceased) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years	Months	Days	If less than one day
90 ?			..... hrs. ..... min.

9. Birthplace Unk. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name John L. C. Smith
13. Birthplace Unk.

MOTHER
14. Maiden name Mollie J. Smith
15. Birthplace Unk.

16. Informant Mrs. Wm. C. Shipley
Address Wash. Loan & Trust Co. Wash DC

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Dec 19, 1948 (month) (day) (year)
Cemetery or crematory Wm Leis Sons Inc
Location 300 - 4th St. N.E.

18. Funeral director Wm Leis Sons Co.
Address 300 - 4th St. N.E.

19. Dec 19 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18 1948 at 11:57 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 42 1947 to 12-18 1948 and that I last saw h e alive on 12-18 1948

Immediate cause of death	DURATION
Acute Cardiac Failure	
Due to Generalized Carcinomatosis	
Due to Carcinoma of Rectum	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of Injury ..... Injured at work?

23. SIGNATURE Dean W. Harding M.D. M. D. or other
Address 113 Carroll St NW Wash DC Date signed 12-19-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1948
40
1858

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95b 12651

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4203 Leland St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Barbara Dunlop Kennedy

3. (b) Social Security Number X

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife E. Russell Kennedy

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 18th 1902

8. AGE: Years	Months	Days	If less than one day
46	7	19	..... hrs. ..... min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George Dunlop

13. Birthplace Washington, D.C.

MOTHER 14. Maiden name Frances Ailer

15. Birthplace Virginia

16. Informant E. Russell Kennedy

Address 4203 Leland St., Chevy Chase, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 10/48 (month) (day) (year)

Cemetery or crematory National Memorial Park

Location Falls Church, Va.

18 Funeral director Wm. Rankin Sons Reg. Funeral Home

Address 7557 Wisc. Ave., Bethesda, Md.

19. 12-9 (Date rec'd by registrar) 19 48 W.E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 / 7 1948 at 2.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1943 to See 5th 1948

and that I last saw h.. alive on See 5th 1948

	DURATION
Immediate cause of death Cerebral Embolism	10 Minutes
Due to Rheumatic Heart Disease	20 Yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Lewis Towson M.D. or other

Address 8016 Georgetown Road Data signed 12/9/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12652

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

469

Reg. Dist. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Yrs

Hospital, institution, or street address where death occurred:
620 Anderson Ave., Rockville, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 620 Anderson Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Sue Fontaine Keys

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thomas C. Keys

Deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 4th 1877

8. AGE:

Years	Months	Days	If less than one day
71	8	14	hrs. min.

9. Birthplace: Somerset County, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Henry Fontaine
13. Birthplace: Somerset County, Md.

MOTHER
14. Maiden name: America Magruder
15. Birthplace: Montgomery Co., Md.

16. Informant: Miss Josephine R. Keys
Address: 620 Anderson Ave., Rockville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 21/48 (month) (day) (year)

Cemetery or crematory: Rockville Union Cemetery

Location: Rockville, Md.

18. Funeral director: Wm. Reuben Pumphrey Funeral Home

Address: 7557 Wisconsin Ave., Bethesda

19. 12/21 1948 (Date rec'd by registrar) E. P. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 19 1948 at 1245 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 19 to Dec. 19 1948 and that I last saw h. alive on Dec. 18 1948.

	DURATION
Immediate cause of death	
Carcinoma of pancreas	1 year.
Due to	
Due to	
Other condition Hemorrhage Gastrointestinal	3 days

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm. A. Smithwick M.D.
M. D. or other

Address: Rockville, Md. Date signed 12/19/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932d

12653

Reg. Diat. No. 714

1. PLACE OF DEATH:

County: Montgomery Silver Spring

City or town: 10060 Geo Ave Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: Washington D C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3273 Garfield St NW

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

Eleanor B. Koones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles H Koones M D

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 18, 1867

8. AGE: Years 81 | Months 9 | Days 8 | If less than one day: hrs. min.

9. Birthplace: Pr. Geo Co Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Thomas Sprigg Blandford

13. Birthplace: Pr. Geo. Co. Md

MOTHER

14. Maiden name: Elizabeth Hill

15. Birthplace: Pr. Geo. Co. Md

16. Informant: Charles E. Koones

Address: 5202 Edgemoor Lane Bethesda Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-28-48 (month) (day) (year)

Cemetery or crematory: Rock Creek.

Location: Washington D C

18. Funeral director: James T. Ryan Inc

Address: 317 Pa ave S.E.

19. Dec 26 1948 (Date rec'd by registrar) Josephine A Hartle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26 1948 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1948 to Dec. 26 1948 and that I last saw h[illegible] alive on December 26 1948

Immediate cause of death: Cerebral Thrombosis — DURATION: 1 wk.

Due to: Chronic myocarditis — DURATION: —

Due to: Senility — DURATION: —

Other conditions: — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry Jay Lowden M.D. M. D. or other

Address: 1603 19th St. NW Date signed: 12-26-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1700

12654

414

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
On street in front of 235 Dale Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 431 Cedar Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Fred L. Manuel

3.(b) Social Security Number: 578-07-8113

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Hilda A. Manuel

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 11, 1887

8. AGE: Years	Months	Days	If less than one day
61	0	9	hrs. min.

9. Birthplace: Middletown, Va.
(Town, county, and state)

10. Usual occupation: Carpenter Superintendent

11. Industry or business:

FATHER
12. Name: Davis Manuel
13. Birthplace: Shepherdtown, Va.

MOTHER
14. Maiden name: Margaret Frances
15. Birthplace: Shepherdtown, Va.

16. Informant: Mrs. Hilda A. Manuel
Address: 431 Cedar St., N. W., Washington, DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 23, 1948 (month) (day) (year)

Cemetery or crematory: Middletown

Location: Middletown, Va.

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19. Dec 21 1948 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20 19 48 at 3:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemorrhage due to Crushed Chest	Instantly
Due to: (accidental)	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 12-20-48

Where did injury occur? Silver Spring (City or town) Mont. (County) Md (State)

Injured at home, farm, industry, public place (where?) street

Means of injury: Crushed by truck Injured at work? yes

23. SIGNATURE: Frank J. Brockhurst M.D.
Dep. Med. Exam.
M. D. or other

Address: Gaithersburg Md Date signed: 12-20-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12655

46g

Reg. Dist. No. 216

M

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Bethesda Suburban Hospital.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1009 Reddick Drive (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: CHARLES MATHENY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Bessie L. Matheny

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 13, 1893

8. AGE: Years	Months	Days	If less than one day
55	4	10	..... hrs. ..... min.

9. Birthplace: Clarksburg, W.Va. (Town, county, and state)

10. Usual occupation: Building Contractor

11. Industry or business: Matheny Corporation

FATHER

12. Name: James L. Matheny

13. Birthplace: Clarksburg W.Va.

MOTHER

14. Maiden name: Matilda Moore

15. Birthplace: Fairmont W.Va.

16. Informant: Mrs. Bessie L. Matheny

Address: 1009 Reddick Dr. Sil. Springs Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/24/48 (month) (day) (year)

Cemetery or crematory: Macon

Location: Macon, W.Va.

18. Funeral director: L. H. Hines Co.

Address: 2901-14th Street, N.W. Wash., DC.

19. 12-23 1948 (Date rec'd by registrar) W.E. Joe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 23, 1948 19.... at 10.30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 22, 1948 19.... to Dec. 23, 1948 and that I last saw him alive on Dec. 23, 1948 19....

Immediate cause of death	DURATION
Carcinoma of the pancreas	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Gallstones; hepatic mestastases

Date of op. Dec. 2-48

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frederick C. Fishback M. D. or other

Address: 1835 Eye St. Wash. 6. D. C. Date signed: Dec. 23, 1948.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50 12656

CERTIFICATE OF DEATH

Reg. Dist. No. 314

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
113 Silver Spring Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montg.

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 Silver Spring Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME DELLA E. MATHIAS

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife John W. Mathias

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 31, 1860

8. AGE: Years	Months	Days	If less than one day
88	8	19	..... hrs. ..... min.

9. Birthplace Howard Co., Md.
(Town, county, and state)

10. Usual occupation Retired Housewife

11. Industry or business

FATHER
12. Name James Foreman
13. Birthplace Pa.

MOTHER
14. Maiden name Susannah Helterbridal
15. Birthplace Pa.

16. Informant Mr. Raymond E. Lindsay

Address 3125 McComas Ave., Kensington, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 22, 1948 (month) (day) (year)

Cemetery or crematory Burtonsville Union Cemetery

Location Burtonsville, Md.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. Dec 21 1948 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1948 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1.0 1945 to Dec 20 1948 and that I last saw h.... alive on Dec 20 1948

	DURATION
Immediate cause of death Carcinoma Breast	4 years
Due to Metastasis to Liver, Lungs & Skin	
Due to	
Other conditions Congestive Cardiac Dilatation	30 min

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W B Wardrop MD M. D. or other

Address 937 Bonifant St Silver Spring Md Date signed 12/20/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age if especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

12657

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

922

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 54 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 11 W. Kirke St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Helen Hayden May

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Henry A. May
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov 6 - 1868

8. AGE:

Years	Months	Days	If less than one day
80	1	19	____ hrs. ____ min.

9. Birthplace: Rochester Minn
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Wm Richardson
FATHER 13. Birthplace: England
MOTHER 14. Maiden name: Mary Victoire Evans Hayden
MOTHER 15. Birthplace: Ellicott City, Md
16. Informant: Miss Lucy Mackiles
Address: 11 W. Kirke St. Chevy Chase, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 29 - 48 (month), (day), (year)
Cemetery or crematory: Kensico Cem.
Location: Valhalla N.Y.
18. Funeral director: The J. W. Jones Co.
Address: 2901 14th St N.W.
19. 12-28 19 48 W E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 19 48 at 7 30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 47 to Dec 25 19 48 and that I last saw h.er alive on Dec 23 19 48

Immediate cause of death	DURATION
Congestive heart failure	6 mos.
Due to: Chr. Myocarditis	2 years
Due to: Chr Arterio sclerosis hypertension	2 years
Due to: Chr Valvular heart disease	2 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John A Logan M.D.
M. D. or other
Address: 600 Nevada Ave NW Date signed: Dec 25-1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

132 12658

CERTIFICATE OF DEATH

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montg Co,

City or town: Gaithersburg Md,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 Yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: GAITHERSBURG

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William McBain

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Orra A. McBain

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Mar 5th 1869

8. AGE:

Years	Months	Days	If less than one day
79	9	14	hrs. min.

9. Birthplace: Scottland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: George McBain

13. Birthplace: Scottland

MOTHER

14. Maiden name: Mary Gordon

15. Birthplace: Scottland

16. Informant: Mrs Orra McBain

Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/22/48 (month) (day) (year)

Cemetery or crematory: ForedstOak Cemetery

Location: Gaithersburg Md,

18. Funeral director: Ernest C. Gartner

Address: Gaithersburg Md,

19. Dec 22 1948 (Date rec'd by registrar) Alveda G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 19th 1948 at 5.15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April - 7 - 1947 to Dec - 19 - 1948 and that I last saw him alive on Dec - 19 - 1948

Immediate cause of death	DURATION
cerebral hemorrhage	20 months
Due to Complications	
Pernicious malaria infection	
Due to Myocardial insufficiency	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wallace C. Miller M.D.

M. D. or other

Address: Gaithersburg, Md Date signed 12/20/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Rural, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
U S Naval Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Dist. Columbia County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 441 Kings Courts
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 2

3.(a) FULL NAME

MEREDITH, Robert Edgar

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife: Nellie Meredith

Deceased 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8-3-1912

8. AGE: Years	Months	Days	If less than one day
36	4	21	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Chef

11. Industry or business: Private

FATHER
12. Name: Edward Meredith
13. Birthplace: Virginia deceased

MOTHER
14. Maiden name: Lannie Lewis
15. Birthplace: Virginia deceased

16. Informant: Sister: Ethel Campbell

Address: 1358 Girard St, NW, Washington, DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-29-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington

18. Funeral director: Henry S. Washington (H.M.W.)

Address: 467"N" Street NW, Washington, DC

19. 12-24-48 (Date rec'd by registrar) 19..... Mary C. Patterson Registrar

Mary C. Patterson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 December 19 48 at 1215P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-20-48 19.. to 12-24-48 19.. and that I last saw h im alive on 12-24-48 19..

	DURATION
Immediate cause of death: Pancreatitis, acute	4 days
Due to: Alcoholism, acute	15 days
Due to:	
Other conditions: Cyclosis, Toxic	2 days

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: V. E. Lowery LTJG MC USN
M. D. or other

V. E. Lowery

Address: U S Naval Hospital Date signed: 12-24-48

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I

12660

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 414

1. PLACE OF DEATH:

County Montgomery, County

City or town
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 2908 Woodstock ave; Silver Spring Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2908 Woodstock ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Adolph Messitte

3.(b) Social Security Number

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1879

8. AGE: Years 69 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Poland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Joel Messitte

13. Birthplace Poland

MOTHER 14. Maiden name unknown

15. Birthplace Poland

16. Informant Jesse B Messitte

Address 7613 De Russey Pkwy Ch. Ch. Md

17. Burial Date thereof 12/2/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location New York, N.Y.

18. Funeral director B. Danzansky & Son

Address 3501-14th St NW Wash. D.C.

19. Dec 2 1948 Joseph M Schaaf
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1948, at 9 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4, 1948, to December 2, 1948 and that I last saw him alive on November 25, 1948

	DURATION
Immediate cause of death Coronary occlusion	minutes
Due to Arteriosclerotic heart disease	many years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel T. Kimble, M.D.
M. D. or other

Address 1711 Page St. N.W. Date signed Dec 2, '48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

526

12661

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Wood Acres
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs.
Hospital, Institution or street address where death occurred 5905 Wynnwood Rd, Wood Acres, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Wood Acres
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5905 Wynnwood Rd, Woodacres
(If rural, give LOCATION)
2.(a) If veteran, name war None.

3.(a) FULL NAME Ellsworth M. Metcalf

3.(b) Social Security Number None.

4. Sex M.

5. Color or race W.

6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of ~~husband~~ or wife Carrie Amanda.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1864

8. AGE: Years 84 Months 11 Days ..... If less than one day ..... hrs. ..... min.

9. Birthplace Grantham, N.H. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Farmer.

FATHER
12. Name William H. Metcalf.
13. Birthplace Unknown.

MOTHER
14. Maiden name Elizabeth Sargent.
15. Birthplace Unknown.

16. Informant Mrs. Alta L. Mainwaring
Address 5905 Wynnwood Rd, Wood Acres Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 18, 1948 (month) (day) (year)
Cemetery or crematory Gurnee, Ill.
Location

18. Funeral director W.W. Chambers Co.
Address 1400 Chapin St. N.W. Wash. D.C.

19. 12/15 1948 W Eyles
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1948, at 7:24 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 12 1948 to Dec. 15 1948 and that I last saw him alive on Dec. 15 1948.

	DURATION
Immediate cause of death Pulmonary edema	1 da
Due to General arterio-sclerosis	10 yr.
Due to Carcinoma of bladder	3 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE F.M. McChesney M. D. or other
Address 4620 36th St. NW Date signed Dec 15/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12662

932

CERTIFICATE OF DEATH

Reg. Dist. No. 125 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Rural, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, Institution, or street address where death occurred:
U S Naval Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County:

City or town: Alexandria
(If outside city or town limits, write RURAL and give nearest town)

Street No. 108 Reed Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1

3. (a) FULL NAME
MITCHELL, Jack David

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen Mitchell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4-11-1896

8. AGE: Years	Months	Days	If less than one day
52	8	13	hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Sterotypist

11. Industry or business: Washington Post

FATHER
12. Name: Frank Mitchell
13. Birthplace: Tennessee deceased

MOTHER
14. Maiden name: Annie Valmer
15. Birthplace: Tennessee deceased

16. Informant: Wife: Helen Mitchell
Address: 108 Reed Ave, Alexandria, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-30-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington Virginia

18. Funeral director: W.W.Chambers J.D.P.

Address: 1400 Chapin St, NW, Washington, DC

19. 12-24-48 19 (Date rec'd by registrar)

Mary C. Patterson
Registrar

MEDICAL CERTIFICATION 215

20. DATE OF DEATH: 24 December 19 48 at PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 December 1948, to 24 December 1948 and that I last saw him alive on 24 December 1948

Immediate cause of death	DURATION
Thrombosis Coronary	Hours
Due to: Coronary Heart Disease	
Arteriosclerotic	Indef
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H.R.Cooper H.R.COOPER LT MC USN
M. D. or other

Address: U.S.Naval Hospital Date signed: 12-24-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

182653

1312

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 507 Harding Drive
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harold Morgan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 26, 1899

8. AGE: Years: 49 | Months: 8 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Springfield, Mass. (Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business:

FATHER
12. Name: Leslie Morgan
13. Birthplace: Springfield, Mass

MOTHER
14. Maiden name: Ruth McKenstrie
15. Birthplace: Springfield, Mass.

16. Informant: Cadvil Payne (friend)
Address: Dennis Ave - Sil. Sp. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-3-48 (month) (day) (year)
Cemetery or crematory: Oakwood Cemetery
Location: Falls Church Va.

18. Funeral director: C. J. Clues
Address: 2847 Wilson Blvd. Arlington, Va

19. 12-2-48 (Date rec'd by registrar) 19 W E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 1, 1948 at 11½ P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 12-1 1948
and that I last saw h alive on 12-1-48 19

Immediate cause of death	DURATION
Uremia	
Due to: Hypertensive Cardiovascular Disease	
Due to: Chronic Glomerulonephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James E. Boyland, M.d. M. D. or other
Address: Suburban Hospital Date signed: 12-2-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12664

Reg. Diat. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 21 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1726 S. Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: Sp.Am. ✓

3. (a) FULL NAME: NETTLES, James Avery

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	married

6.(b) Name of husband or wife: Mrs. Bertha L. Nettles

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 10, 1882

8. AGE: Years	Months	Days	If less than one day
66	6	13	..... hrs. ..... min.

9. Birthplace: N.C.
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: Railroad

FATHER
12. Name: NETTLES, Robert dec.
13. Birthplace: N.C.

MOTHER
14. Maiden name: WILSON, Nancy dec.
15. Birthplace: S.C.

16. Informant: WIFE: Mrs. Bertha L. Nettles

Address: 1726 S. St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12-28-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: ~~Mrxx~~ W. Ernest Jarvis

Address: 1432 U St. N.W., Wash., D.C.

19. 12-24- 19 48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23 19 48 at 9:48 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 November 19 48 to 23 December 19 48 and that I last saw him alive on 23 December 19 48

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Hypertensive - Heart Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: V. E. Lowery V. E. LOWERY, Lt. JG MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 12-24-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12665

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: SILVER SPRING

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

10109 Big Rock Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: SILVER SPRING

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10109 Big Rock Road.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARY ELIZA NICOLL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE.	WIDOWED

6.(b) Name of husband or wife: CLYDE CLARENCE NICOLL

7. Birth date of deceased (mo., day, yr.): JULY 9 1884 6.(c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
64	5	10	hrs. min.

9. Birthplace: PINEWOOD TENN.

(Town, county, and state)

10. Usual occupation: HOUSEWIFE.

11. Industry or business

FATHER

12. Name: JOHN WALKER DUNCAN

13. Birthplace: TENN.

MOTHER

14. Maiden name: MARY ALICE HARMAN.

15. Birthplace: TENN.

16. Informant: CLYDE DUNCAN NICOLL

Address: 10109 Big Rock Road.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof DEC. 21, 1948 (month) (day) (year)

Cemetery or crematory: HOLLYWOOD CEMETARY

Location: JACKSON TENN.

18. Funeral director: THE S. H. HINES CO

Address: 2901 14th St. N.W. WASHINGTON, D.C.

19. Dec. 19 1948 Josephine Schaeffer Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 19 1948 at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 29 1948 to Dec. 19 1948

and that I last saw her alive on Dec. 19, 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 hrs.
Due to: Generalized arteriosclerosis and hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John E. Everett M.D. M. D. or other

Address: 630 - 14th St. N.W. Date signed 12/14/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

12666

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164c

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 71 Decatur St.
(If rural, give LOCATION)
2.(a) If veteran, name war W.W. 11 - Navy

3.(a) FULL NAME Robert Leroy Norris

3.(b) Social Security Number 215-20- 3470

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife None
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 23, 1925

8. AGE:	Years	Months	Days	If less than one day
	23	2	7	..... hrs. ..... min.

9. Birthplace Kensington, Montgomery, Maryland (Town, county, and state)
10. Usual occupation Sheet metal worker
11. Industry or business

FATHER
12. Name Wm. L. Norris
13. Birthplace Rockville, Md.

MOTHER
14. Maiden name Daisy H. Crist
15. Birthplace Nelson Co. Virginia

16. Informant Mrs Daisy Norris
Address 71 Decatur St. Kensington, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 5, 1949 (month) (day) (year)
Cemetery or crematory Arlington National Cemetery
Location Arlington, Virginia

18. Funeral director Wm Reuben Pumphrey Funeral Home
Address Bethesda, Maryland

19. 1-1-49 (Date rec'd by registrar) W.E. Joe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Def med Exam Case 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Shot gun wound from skull	instantaneous
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of 12.30.48
Where did injury occur? Kensington (City or town) Montg (County) Md (State)
Injured at home, farm, industry, public place (where?) home
Means of injury Shot gun Injured at work? no

23. SIGNATURE Frank J. Borchart M.D. Def. Med. Exam. M. D. or other
Address Gaithersburg Md Date signed 12-31-48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12667

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Rural, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 days
Hospital, institution, or street address where death occurred:
U.S.Naval Hospital
How long in hospital or institution? 40 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: P.G
City or town: Hillside
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1319 57th Street
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American

3.(a) FULL NAME: OSBORN , John Robert

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: ..... 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3-24-76

8. AGE: Years	Months	Days	If less than one day
72	8	29	..... hrs. ..... min.

9. Birthplace: District of Columbia (Town, county, and state)
10. Usual occupation: Plumber
11. Industry or business:
FATHER 12. Name: John L. Osborn
13. Birthplace: Maryland deceased
MOTHER 14. Maiden name: Liza Smith
15. Birthplace: Maryland deceased
18. Informant: Son: Wade H. Osborn
Address: 1319 57th Ave, Hillside, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-24-48 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Maryland
18. Funeral director: Robert Mattingly N.L.H.C.
Address: 131 11th St, S.E. Washington D.C.
19. 12-23-48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 December 1948, at 1501 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 November 1948 to 23 December 1948
and that I last saw h... im alive on 23 December 1948

Immediate cause of death	DURATION
Hypostatic Pneumonia	
Due to: Coronary Heart disease	
Due to: Generalized arterial sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation: ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Stephen R. Mills, LtJGMC USN
M. D. or other
Address: U S Naval Hospital Date signed: 12-23-48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 12668

CERTIFICATE OF DEATH

Reg. Dist. No. 215

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months, 12 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 8 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3901 Connecticut Avenue, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: Thomas McAdory OWEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Elizabeth Owen

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 10, 1894

8. AGE: Years	Months	Days	If less than one day
54	7	25	____ hrs. ____ min.

9. Birthplace: Alabama
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business:

FATHER
12. Name: OWEN, Thomas M.
13. Birthplace: Ala.

MOTHER
14. Maiden name: BANKHEAD, Marie
15. Birthplace: Ala.

16. Informant: wife: Mrs. Elizabeth Owen
Address: 3901 Connecticut Avenue, N.W., Wash., D.C.

17. burial Removal Date thereof: Dec 5 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Oakridge Cemetery
Montgomery, Ala.

Location:

18. Funeral director: W. H. Chambers
Address: 1400 Chapin St. N.W., Wash, D.C.

19. 12-5- 1948 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 1948, at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 23 March 1948, to 5 December 1948 and that I last saw him alive on 5 December 1948

	DURATION
Immediate cause of death: Congestive Heart Failure	5 Da.
Due to: Hypertensive Cardio-Vascular Disease	3 yrs.
Due to: Anemia	
Other conditions: Anemia, Secondary; Arteriosclerosis, generalized	3 mo. 3 years

(Include pregnancy within 3 months of death)

Major findings of operation: none Date of op.:

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. C. Messerschmidt, Jr., Lt. JG
M. D. or other: MC USNR

Address: USNH Bethesda, Md. Date signed: 12-5-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12669

Reg. Diat. No. 26

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase
(If outside City or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
9 West Lenox Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 West Lenox Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME MARY LOIS PASCHAL

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife Samuel Scoville Paschal 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1875

8. AGE: Years	Months	Days	If less than one day
73	11	24	hrs. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Henry Clay Sherman
13. Birthplace Md.

MOTHER
14. Maiden name Sue McConnell
15. Birthplace Washington, D. C.

16. Informant Mrs. J. W. Jones (sister)
Address Olney, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 3, 1949 (month) (day) (year)

Cemetery or crematory Friends' Cemetery

Location Sandy Spring, Md.

18. Funeral director Warner E. Pumphrey, Inc.

Address 8434 Georgia Ave., Silver Spring, Md.

19. 1-2-49 19 M.E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1948 at 11 P M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27 1948 to Dec. 29, 1948 and that I last saw her alive on Dec. 29, 1948

	DURATION
Immediate cause of death: Acute myocardial failure	
with pulmonary edema	2 hrs.
Due to: advanced leukemia	
+ secondary anemia	6 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: no surgery Date of op.

Autopsy results: none performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James W. Long, M.D.
M. D. or other

Address 1835 Eye St. N.W. D.C. Date signed 12/30/48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

12670

1. PLACE OF DEATH:
County MONTGOMERY
City or town BETHESDA MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11-4-48
Hospital, Institution, or street address where death occurred:
SUBURBAN Hosp. BETHESDA MD.
How long in hospital or institution? SINCE - 11-4-48

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County
City or town WASHINGTON.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 818 - 49th Ave, CAPITOL HEIGHTS MD.
(If rural, give LOCATION)
2.(a) If veteren, name war

3. (a) FULL NAME PEGGY PIGNATARO

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife JOSEPH Pignataro
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-19-1929

8. AGE: Years	Months	Days	If less than one day
19	1	28	hrs. min.

9. Birthplace RACINE, WISCONSIN
(Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name THEODORE HENDERSON
13. Birthplace FLINT, MICH.

MOTHER
14. Maiden name MARTHA HANSON
15. Birthplace FLINT, MICH.

16. Informant HUSBAND
Address 818 - 49th ave, Capt. Hghts. Md

17. Removal Date thereof 12-20-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Prince Geo. Co. Md.

18. Funeral director Chambers. Co
Address 517 - 11-ST S.E. Wash. D.C.

19. 12-18 19 48 M.E. Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Dec. 19 48, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 19 48 to 12-17 19 48
and that I last saw h alive on 19

Immediate cause of death	DURATION
Renal failure with Azotemia secondary to chronic glomerulo nephritis	10-7-48
Due to (2) Azotemia Precipitating	11-30-48
(3) Left Ventricular failure	
Due to (1) Cardiovascular renal disease (Hypertension)	12-2-48
Other conditions Chronic glomerulonephritis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE Andrew J. Grandoni M.D.
M. D. or other
Address 11 SD Comm Apt NW Wash. D.C. Date signed 12-17-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Use correct age if especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

48a

12772

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 13 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Garrett Park (If outside city or town limits, write RURAL and give nearest town)
Street No. 23 Albemarle St (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Alice Porter

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: widow
6.(b) Name of husband or wife: Albert
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct. 10, 1882.
8. AGE: Years: 66 Months: 1 Days: 23 If less than one day: hrs. min.
9. Birthplace: Austin, Texas (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Megee
13. Birthplace: Texas
MOTHER 14. Maiden name: A. Wilson
15. Birthplace: Texas
16. Informant: Mrs. B. J. Cleaves (daughter)
Address: same
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 3/48 (month) (day) (year)
Cemetery or crematory: Belleview Cemetery
Location: Danville, Kentucky
18. Funeral director: Wm Reuben Pumphrey
Address: 7557 Wis. Ave., Bethesda, Md.
19. 12-4 1948 (Date rec'd by registrar) W E Jobe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 3, 1948 at 10 P. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 18 1948 to Dec. 3 1948 and that I last saw h[illegible] alive on Dec. 3 1948

	DURATION
Immediate cause of death: Cardiac failure	2 hours, or less
Due to: Hyperemia of lungs	2 hours, or less
Due to: Metastatic carcinoma in abdominal glands	1 yr.
Due to: Carcinoma of cervix	2½ yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results: see above - also later report.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Katharine A. Chipman M.D. M. D. or other
Address: 20 West Baltimore St. Kensington, Md. Date signed: Dec. 3, 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12672

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 300 West Montgomery Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: William Reuben Pumphrey

3. (b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Irene Pumphrey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 10, 1885

8. AGE: Years: 63 | Months: 5 | Days: 25 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Rockville, Montgomery, Maryland
(Town, county, and state)

10. Usual occupation: Funeral Director-Mortician

11. Industry or business: Funeral Home

FATHER
12. Name: Wm Reuben Pumphrey, Sr.
13. Birthplace: Rockville, Md.

MOTHER
14. Maiden name: Harriett Schekell
15. Birthplace: Montg. Md.

16. Informant: Robert A. Pumphrey
Address: 7557 Wisconsin Ave., Bethesda

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 8, 1948 (month) (day) (year)

Cemetery or crematory: Rockville Union

Location: Rockville, Md.

18. Funeral director: Wm Reuben Pumphrey Funeral Home

Address: 7557 Wisconsin Ave.

19. 12-6 (Date rec'd by registrar) 19 48 W.E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 Dec 19 48, at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 47 to 5 Dec 19 48 and that I last saw h.. alive on 5 Dec 19 48

	DURATION
Immediate cause of death: Coronary Thrombosis	2 days
Due to: Hypertension	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Nature of injury ..... Injured at work?

23. SIGNATURE: W.S. Murphy M.D. M. D. or other

Address: Rockville Md. Date signed: 5 Dec '48

11-35
1748-7-4
1585-6-10
62-3-22

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

109a 12673

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months, 3 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 9 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: PG

City or town: Cottage City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3705 40th Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI ✓

3. (a) FULL NAME

RAY, James Earl

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Alice B. Ray

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 22, 1888

8. AGE: Years	Months	Days	If less than one day
60	6	5	..... hrs. ..... min.

9. Birthplace: N.C. (Town, county, and state)

10. Usual occupation: Auto Mechanic

11. Industry or business

FATHER — 12. Name: RAY, James H. dec.

13. Birthplace: N.C.

MOTHER — 14. Maiden name: SCOTT, Elwillie dec.

15. Birthplace: N.C.

16. Informant: WIFE: Mrs. Alice B. Ray

Address: 3705 40th Avenue, Cottage City, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-31-48 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Wm. J. Nalley W.J.N.

Address: 3200 Rhode Island Avenue, Mt. Rainier, Md.

19. 12-28- (Date rec'd by registrar) 19 48 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 December 19 48 at 9:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 March 19 48 to 27 December 19 48 and that I last saw him alive on 27 December 19 48

Immediate cause of death	DURATION
Friedlanders Pneumonia	8 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: f—

Date of op.

Autopsy results: Friedlanders Pneumonia Gangrene

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Dallas E. Billman

D. E. BILLMAN, Lt. MSC USN. D. or other

Address: USNHBethesda, Md. Date signed 12-28-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

EVIDENCE FOR ADDITION OF AGE + BIRTH DATE SHOWN ON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 118 JAN 21 1949 **CERTIFICATE OF DEATH** 46 f 8

12674

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Rural, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

U S Naval Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County: [illegible]

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. c/o Mrs. C. R. Baker, 3511 Davenport St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

ROARY, Arthur (n)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Unknown

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ~~Unknown~~ 1879-?

8. AGE: Years	Months	Days	If less than one day
~~Unknown~~ 60	Unkn.	Unkn	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Houseman

11. Industry or business

FATHER 12. Name: Charles Roary

13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Employer M.D.Willcutts RADM USN

Address: MOinC, National Naval Med. Center

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-4-49 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: Washington, D.C.

18. Funeral director: W.E. Jarvis LH

Address: 1432 U Street NW, Wash. D.C.

19. 12-31-48 (Date rec'd by registrar) 19 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 December 1948 at 817P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 December 1948 to 30 December 1948 and that I last saw him alive on 30 December 1948

	DURATION
Immediate cause of death: Primary Carcinoma at ampula of Vater c Acute + Complete Biliary	
Due to: obstruction	7 weeks
Due to:	
Other conditions: Jaundice, Sarcoma R thigh, Pul. edema, art. Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operation: Biliary obstruction at ampula of Vater Date of op. 12-27-48

Autopsy results: Tumor (~~malignant~~?) ampulla of Vater

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

B.F. Baisch

23. SIGNATURE: B.F. BAISCH LTJG MC USN

M. D. or other

Address: U.S. Naval Hospital Date signed: 12-31-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12675

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Rural, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
U.S.Naval Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County: Arlington

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1526 22nd Street
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American

3.(a) FULL NAME: ROBERTS, Jasper Newton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jessie Lea Roberts

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 11-1-1879

8. AGE: Years	Months	Days	If less than one day
69	1	24	..... hrs. ..... min.

9. Birthplace: Tennessee
(Town, county, and state)

10. Usual occupation: Doctor of Dental Surgery

11. Industry or business: Own

FATHER
12. Name: John Roberts
13. Birthplace: Tennessee deceased

MOTHER
14. Maiden name: Donna Magill
15. Birthplace: Tennessee deceased

16. Informant: Son: John L.Roberts
Address: 1526 22nd St,N.Arlington,Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-28-48 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington National, Virginia

18. Funeral director: Joseph Gawler per R. Fowler
Address: 1756 Pennsylvania Ave WashDC

19. 24 December 48 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 December 1948 at 710A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 December 1948 to 24 December 1948 and that I last saw him alive on 24 December 1948

Immediate cause of death	DURATION
Obstruction Intestinal	
External Causes #341	Indef
Due to: Carcinoma, Hepatoma Primary	Indef
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: H.R.COOPER LT MC USN
M. D. or other

Address: U.S.NAVAL HOSPITAL Date signed: 12-24-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

12676

Reg. Diat. No. 218

1. PLACE OF DEATH:

County Montg Co,

City or town Gaithersburg Md,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 53yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Mont

City or town Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William Daniel Robertson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillie Lane Robertson

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Feb 28th 1870

8. AGE:

Years	Months	Days	If less than one day
78	9	26	....hrs. ....min.

9. Birthplace: Va, (Town, county, and state)

10. Usual occupation: Retired,

11. Industry or business: Telegraph Operator

FATHER

12. Name: John Robertson

13. Birthplace: Va,

MOTHER

14. Maiden name: Martha Hobson

15. Birthplace: Va,

16. Informant: Lillie L, Robertson

Address: Gaithersburg. Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/27/48 (month) (day) (year)

Cemetery or crematory: Forest Oak Cemetery

Location: Gaithersburg Md,

18. Funeral director: Ernest C. Gartner

Address: Gaithersburg Md,

19. Dec 27 1948 (Date rec'd by registrar) Glenda L. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 24th 1948, at 6.30PM

I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 1943, to Dec-24-1948

and that I last saw him alive on Dec-24-1948

Immediate cause of death	DURATION
2nd Cerebral Hemorrhag	2½ hours
1st " "	3 years
Due to	
Due to senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William L. Miller M.D. M. D. or other

Address: Gaithersburg Md Date signed 12/27/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12677

1178

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 9 days

Hospital, institution, or street address where death occurred: Fair Hill Rest Home 207 Hudson Ave

How long in hospital or institution? 2 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Texas County: Harris

City or town: Houston

(If outside city or town limits, write RURAL and give nearest town)

Street No. St. Joseph's Infirmary

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Miss Margaret Ryan

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 1872 ?

8. AGE: Years: 76 Months: 5 Days: ? If less than one day: hrs. min.

9. Birthplace: Thurles Ireland (Town, county, and state)

10. Usual occupation: Dressmaker

11. Industry or business:

FATHER

12. Name: Dennis Ryan

13. Birthplace: Thurles, Ireland

MOTHER

14. Maiden name: Margaret Hassett

15. Birthplace: Thurles Ireland

16. Informant: Miss Margaret McCormack

Address: 700 Jefferson St. N.W. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-9-48 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland Md.

18. Funeral director: Francis Coleman

Address: 3821-14th St. N.W. Wash. D.C.

19. Dec. 5 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 1948, at 8 35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10:30 Am Dec. 5 1948, to 7:30 pm. Dec. 5 1948

and that I last saw h.r alive on December 5, 1948

	DURATION
Immediate cause of death: Gastro-intestinal hemorrhage	11 hrs.
Due to: Duodenal Ulcer (From Xray Report May 28, 1947)	18 mo.
Due to: Arteriosclerosis, generalized Years and Hypertension, arteriosclerotic Years	
Other conditions: Senile Dementia	18 mo.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wallace H. Mook M.D. M. D. or other

Address: Takoma Park, Md. Date signed 12-5-48

VS A15 9-45-17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. F. J. Bioschart, Medical Examiner for Montgomery County notified.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

12678

CERTIFICATE OF DEATH

Reg. Dist. No. 2233

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 317 Ethan-Allen Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war No.

3. (a) FULL NAME Mrs. Sarah Ford Ryan

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John J. Ryan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 1 1874

8. AGE: Years	Months	Days	If less than one day
74	11	18	..... hrs. ..... min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER — 12. Name Michael Ford

13. Birthplace Ireland

MOTHER — 14. Maiden name Unknown

15. Birthplace

16. Informant Catherine A. Hazen

Address 2121 Virginia Ave. N.W. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 - 22 - 48 (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Washington D.C.

18. Funeral director The S.J. Stines Co.

Address 2901-14th Street N.W. Washington, D.C.

19. Dec. 19 1948 (Date rec'd by registrar) J. Wilmer Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1948, to Dec. 19 1948 and that I last saw h.. alive on Dec. 19 1948

Immediate cause of death	DURATION
Chronic congestive heart failure	5 yrs.
Due to Generalized arterio-sclerosis	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Francis P. Hannan, M.D. M. D. or other

Address 1511-17th St. N.W. Wash. D.C. Date signed Dec. 19, 1948

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Permission for signature granted by
Dr. J. G. Maloney on Dec. 19. 1948
at 6:30 P.M. by phone.
J. P. Hannan. M.D.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

Reg. Dist. No. 12634 2-23

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hrs + 5 minutes

Hospital, institution, or street address where death occurred:
Walter Reed Hospital

How long in hospital or institution? 4 hrs + 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 314 Whitestone Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war World #1

3.(a) FULL NAME Charles Henry Schauer

3.(b) Social Security Number 055-03-3711

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Vera Ellen Schauer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1896

8. AGE: Years	Months	Days	If less than one day
51	11	23	..... hrs. ..... min.

9. Birthplace Brooklyn, New York
(Town, county, and state)

10. Usual occupation administrator

11. Industry or business

FATHER
12. Name Chas. Henry Schauer
13. Birthplace New York

MOTHER
14. Maiden name Emma Seidel
15. Birthplace New York, New York

16. Informant Son, Henry R.

Address 314 Whitestone Rd., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 23, 1948 (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Fort Myer, Va.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. Dec 21 1948 (Date rec'd by registrar) John D. Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20- 1948 at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1948, to Dec 20 1948 and that I last saw him alive on Dec 20 1948

Immediate cause of death	DURATION
Cerebral hemorrhage	4 hours
Due to Hypertension	8 or 9 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John N. Andrews M.D. M. D. or other

Address Silver Spring Md. Date signed 12-20-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 12680

Reg. Dist. No. 215

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, (Rural), Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 days
Hospital, institution, or street address where death occurred:
U S Naval Hospital
How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Virginia County Arlington
City or town Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3245 Wilson Blvd
(If rural, give LOCATION)
2.(a) If veteran, name war Spanish American

3.(a) FULL NAME SEITZ, Frederick "H"

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Luella Seitz
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 15 1879

8. AGE: Years	Months	Days	If less than one day
69	9	24	..... hrs. ..... min.

9. Birthplace Freeport, Illinois
(Town, county, and state)
10. Usual occupation Tool maker
11. Industry or business

FATHER
12. Name August Seitz
13. Birthplace Illinois deceased

MOTHER
14. Maiden name Martha Beck
15. Birthplace Mass. deceased

16. Informant Wife Luella Seitz
Address 1248 N.Taylor St Arlington VA

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-14-48 (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington Virginia

18. Funeral director Fitzgerald Funeral Home
Address 3245 Wilson Blvd, Arlington, VA

19. 12-9-48 (Date rec'd by registrar) 19..... Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1948 at 2:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 November 1948 to December 9 1948 and that I last saw him alive on 9 December, 1948 19.....

Immediate cause of death	DURATION
Coronary Heart Disease, Arteriosclerotic	Indef
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W. F. Queen W.F.QUEEN CDR MC USN M. D. or other
Address U S Naval Hospital Date signed 12-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct; age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Montgo
Bethe

U S Na

Mail

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12681

61

Reg. Dist. No. 216

M

1. PLACE OF DEATH:
County Montgomery
City or town Near Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since Dec. 1 - 1947
Hospital, Institution, or street address where death occurred: Waverley Sanitarium - Rockville Pike
How long in hospital or institution? Since Dec. 1 - 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1 West Melrose St.
(If rural, give LOCATION)
2.(a) If veteran, name war NO

3.(a) FULL NAME
Fannie Bell Sherfy

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single Unmarried
6.(b) Name of husband or wife —
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) July 17, 1866

8. AGE: Years 82 | Months 82 | Days 4 | 16 | If less than one day ... hrs. ... min.

9. Birthplace Champlain, Illinois (Town, county, and state)
10. Usual occupation Unemployed
11. Industry or business

FATHER
12. Name Chalmers Sherfy
13. Birthplace Unknown

MOTHER
14. Maiden name Eunice Beach
15. Birthplace Baldwinsville N.Y.

16. Informant Mrs. R. N. Kauffman
Address #1 W. Melrose St. Chevy Chase Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Dec 4 1948 (month) (day) (year)
Name of crematory Cedar Hill Crematory
Location Washington, D. C.

18. Funeral director Wm Reuben Pumphrey
Address Bethesda, Maryland

19. 12-4 1948 W E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1948 at 2:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10 1948 to December 3 1948 and that I last saw her alive on December 3 - 1948.

	DURATION
Immediate cause of death Bronchopneumonia	3 days
Due to Generalized arteriosclerosis	9 years
Due to Cerebral arteriosclerosis	9 years
Other conditions Diabetes mellitus - ulcers of the left thigh	5 years 5 weeks

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Wheeler D. Huff M.D. M. D. or other
Address Bethesda, Md. Date signed Dec 3/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

I

K

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

12682

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 3 months, 1 week, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7303 Flower Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Shipman, Miss Nellie H.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Caue.	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 22, 1863

8. AGE: Years	Months	Days	If less than one day
85	4	26	hrs. min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Retired Linotype Operator

11. Industry or business: U.S. Govt.

FATHER 12. Name: Horatio N. Shipman

13. Birthplace: Unk.

MOTHER 14. Maiden name: — Wilcox

15. Birthplace: Unk.

16. Informant: Sanitarium Records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12-19-48 (month) (day) (year)

Cemetery or crematory

Location: Washington, D.C.

18. Funeral director: Wm. H. Saunders Co

Address: 1400 Chapin St. N.W. Washington D.C.

19. Dec 19 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18, 1948 at 10 P.M. 57

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 8th 1948 to Dec. 18, 1948 and that I last saw h.. alive on December 18, 1948

Immediate cause of death	DURATION
Cerebral thrombosis with Hemiplegia, right	3 mo. 11 days
Due to Hypertensive heart disease	4 years.
Due to Arteriosclerosis, generalized	4 years
Other conditions Tracheo-bronchitis	11 days
Carcinoma, right breast (Include pregnancy within 3 months of death)	7 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wallace N. Mook M.D. M. D. or other

Address: Takoma Park Md. Date signed 12-19-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

12683

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 hours
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 20 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6608 - Georgetown Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Robert Dewey Sprouse

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	single

6.(b) Name of husband or wife: Margaret M. Sprouse (mother)
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec. 7 - 1948

8. AGE: Years	Months	Days	If less than one day
			20 hrs. — min.

9. Birthplace: Bethesda, Montgomery (Town, county, and state) Md.
10. Usual occupation: —
11. Industry or business: —

FATHER
12. Name: William M. Sprouse
13. Birthplace: Warrenton Va.

MOTHER
14. Maiden name: Margaret M. Jones
15. Birthplace: Herndon, Va.

16. Informant: Margaret M. Sprouse, mother
Address: Leedy Locks Rd. Capitol Jct., Md.

17. (Burial, Cremation, Removal. Which?) Burial Date thereof 12-9-48 (month) (day) (year)
Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg, Md.

18. Funeral director: Wm. Reuben Pumphrey
Address: Bethesda, Md.

19. 12-8-48 19.... W. E. Johns, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7, 1948, at 8:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 7, 1948 to Dec. 7th, 1948 and that I last saw him alive on December 7th, 1948

Immediate cause of death	DURATION
Premature birth	—
Due to: Term - 7 months, 3 weeks	
Due to: post placental hemorrhage, —	
Due to: Long driving in auto, and Xmas shopping day	
Other conditions: mother 1 day previous to birth.	

(Include pregnancy within 3 months of death)

Major findings of operations: .... Date of op. ....
Autopsy results: ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE: Wheeler O. Huff M. D. or other
Address: Bethesda, Md. Date signed: Dec. 7 48.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

12684

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Rural, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mo 10 days
Hospital, institution, or street address where death occurred:
U S Naval Hospital
How long in hospital or institution? 7 mo 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dist. Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2208 Mass Avenue NW
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish Amer. W.W.1 ✓

3. (a) FULL NAME
STRAUSS, Joseph (n)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Strauss
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11-16-61

8. AGE: Years	Months	Days	If less than one day
87	1	14	hrs. min.

9. Birthplace: New york
(Town, county, and state)

10. Usual occupation: Retired Navy

11. Industry or business

FATHER
12. Name: Rafael Strauss
13. Birthplace: Germany Deceased

MOTHER
14. Maiden name: Sarah Metzger
15. Birthplace: Germany deceased

16. Informant: Wife: Mary Strauss
Address: 2208 Mass Avenue NW WashDC

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 1-3-48 (month) (day) (year)
Cemetery or crematory: Cedar Hill Burial: Arlington Nat'l.
Location: Washington DC Arl., Va.

18. Funeral director: W. W. Chambers
Address: 3072 M St NW Wash, DC

19. 12-30-48 (Date rec'd by registrar) 19 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 December 19 48 at 305P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 May 19 48 to 30 December 19 48 and that I last saw him alive on 30 December 19 48

Immediate cause of death	DURATION
Biliary obstruction	
Due to: Metastatic carcinoma	
Due to: Carcinoma of Stomach	
Other conditions: Biliary Cirrhosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Stomach and metastases to gastro Hepatic ligament Date of op. 1-3-49

Autopsy results: Ca. of Stomach wides pread metastases

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Philip J. McNamara
Philip J. McNAMARA, Comdr. MC USN
M. D. or other
Address: U S NAVAL HOSP Bethesda, Md. Date signed: 12-30-48

12685

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

114d

Reg. Dist. No. 215

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Rural, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 days

Hospital, institution, or street address where death occurred:
U.S.Naval Hospital.

How long in hospital or institution? 50 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County:

City or town: Spottsylvania
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural
(If rural, give LOCATION)

2.(a) If veteran, name war: World War One

3.(a) FULL NAME: TAYLOR, Richard Fairfax

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Minnie Taylor

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6-18-96

8. AGE: Years	Months	Days	If less than one day
52	6	4	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Willis Taylor
13. Birthplace: Virginia deceased

MOTHER
14. Maiden name: Nancy Pendleton
15. Birthplace: Virginia deceased

16. Informant: Wife: Minnie Taylor
Address: Spottsylvania, Virginia

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 26, 1948 (month) (day) (year)

Cemetery or crematory: Mt Loans

Location: Caroline County, Virginia

18. Funeral director: D.M.KAY L.D.K.

Address: Fredericksburg, Virginia

19. 23 December 1948 (Date rec'd by registrar)

Mary C. Patterson
Mary C. Patterson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 December 1948, at 1125A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 November 1948, to 22 December 1948 and that I last saw him alive on 22 December 1948

	DURATION
Immediate cause of death: SEPTIC	
OPERATIVE	
Due to: ABSCESSES Right Lung	4 Months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ABSCESSES Right Lung

Date of op. 12-21-48

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R.N. SHELLEY CDR MC USN
M. D. or other

Address: U.S.Naval Hospital Date signed 12-23-48

Not due to tbc. Dr. Shelley (2/10/49)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12688

124 b

Reg. Dist. No. 216

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred: Suburban Hosp. 8100 Old Georgetown Rd.

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville Glen Rd.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Rosie E. Trant

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: John W. Trant

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) April 12, 1884

8. AGE: Years	Months	Days	If less than one day
64	7	8	....hrs. ....min.

9. Birthplace Frederick County (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George Plummer

13. Birthplace Maryland

MOTHER 14. Maiden name Taylor

15. Birthplace Maryland

16. Informant Mrs. Marietta Bryant

Address Glen Rd. Rockville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/22/48 (month) (day) (year)

Cemetery or crematory Potomac Methodist Church Cem.

Location Potomac, Maryland

18. Funeral director Wm Reuben Pumphrey Funeral Home

Address 7557 Wisc. Ave., Bethesda, Md.

19. 12-20 1948 (Date rec'd by registrar) W.E. Jobes. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20th 1948 at 12:30 A.M. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DEC. 1st 1948 to DEC. 20 1948 and that I last saw h ER alive on DEC. 20 1948

Immediate cause of death	DURATION
MASSIVE PERITONITIS	
AND MULTIPLE ADHESIONS	
Due to ASCITES	
Due to CIRRHOSIS OF THE LIVER	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op

Autopsy results CIRRHOSIS OF LIVER, PERITONITIS

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isa W. Perlman M.D

For the Physician in charge, Coroner, M.E. or other

Address 8600 Old Georgetown Rd Bethesda, Md. Date signed 12-20-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46d

12687

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Montgomery

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Yr.

Hospital, institution, or street address where death occurred:
915 Viers Mill Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 915 Viers Mill Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME Agostina Marie Vallino

3. (b) Social Security Number Not Known

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Robert Vallino

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 30th 1886

8. AGE: Years	Months	Days	If less than one day
62	2	20	..... hrs. ..... min.

9. Birthplace Italy
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Crucis
13. Birthplace Italy

MOTHER
14. Maiden name Unknown
15. Birthplace Italy

16. Informant Catherine L. Tarallo

Address 915 Viers Mill Rd. Rockville

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 24, 1948 (month) (day) (year)

Cemetery or ~~crematory~~ St. Catherine's

Location Leechburg, Pa.

18 Funeral director Wm. Reuben Dumphrey Funeral Home

Address 7557 Wisconsin Ave., Bethesda, Md.

19. 12/20 1948 (Date rec'd by registrar) E. P. Thompson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Dec 1948, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1948 to 20 Dec 1948 and that I last saw h.. alive on 20 Dec 1948

	DURATION
Immediate cause of death Carcinoma of Stomach with Metastasis	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation do above Date of op. 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. S. Mungley M.D. M.D. or other

Address Rockville Md. Date signed 20 Dec 48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12188

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: ROCKVILLE RFD 5
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
WAVERLEY SANITARIUM
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: MONTGOMERY
City or town: CHEVY CHASE, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5605 CENTER, ST
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: MILTON N WATERMAN

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife: ELIZABETH WATERMAN
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JULY 5, 1873

8. AGE: Years	Months	Days	If less than one day
75	5	1	..... hrs. ..... min.

9. Birthplace: ILLINOIS (Town, county, and state)
10. Usual occupation: RETIRED
11. Industry or business: CITY GOVERTMENT

FATHER
12. Name: MILTON N. WATERMAN
13. Birthplace: ENGLAND

MOTHER
14. Maiden name: — WALKER
15. Birthplace: ENGLAND

16. Informant: Jack H. Alberti
Address: 5605 Center St. Ch. Ch. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: DEC. 9, 1948 (month) (day) (year)
Cemetery or crematory: OTTAWA AVE CEMETERY
Location: OTTAWA, Ill.

18. Funeral director: Francis Keelin
Address: 3821-14th St. NW Wash. DC.

19. 12-6 1948 (Date rec'd by registrar) W.E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DEC. 6 1948 at 3:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT. 17 1948, to DEC. 6 1948
and that I last saw h...m alive on Dec 5 1948

Immediate cause of death	DURATION
Coronary Occlusion	4 DAYS
Due to: Advanced Arteriosclerosis	YEARS
Due to:	
Other conditions: Glaucoma, macular	YEARS

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: M. Keller D. Huff, M.D., or other
Address: Bethesda, Md. Date signed: Dec. 6-48

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12689

516

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, Institution, or street address where death occurred:
Washington Sanitarium + Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7301 Flower ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Harry Samuel Weaver

3. (b) Social Security Number

4. Sex male | 5. Color or race white | 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Rosina Weaver

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8 1865

8. AGE: Years 83 | Months 2 | Days 22 | If less than one day hrs. min.

9. Birthplace Lancaster, Penna.
(Town, county, and state)

10. Usual occupation Retired painter

11. Industry or business

FATHER 12. Name Christian Weaver

13. Birthplace Lancaster Co. Penna.

MOTHER 14. Maiden name Rebecca Bausbaker

15. Birthplace Switzerland

16. Informant Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 3 1949 (month) (day) (year)

Cemetery or crematory F.H. Lynch & Cemetery

Location Baltimore Blvd. at D.C. Line Prince Geo. Co. Md.

18. Funeral director Arthur Walters

Address 254 Carroll St. N.W. Takoma Park 12, D.C.

19. 12/31/48 19 (Date rec'd by registrar) J. Wm. Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30 1948, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 1948 to Dec 30 1948 and that I last saw h alive on Dec 30 1948

	DURATION
Immediate cause of death Coronary Thrombosis with Myocardial Infarction, hypostatic pneumonia	7 days
Due to arteriosclerosis and Cystitis	10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation 0

Date of op.

Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. Holohan M.D. M. D. or other

Address 500 Underwood NW Date signed 12/30/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93a

12690

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: SILVER SPRING. Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 WEEKS.

Hospital, institution, or street address where death occurred: MAPLE LANE NURSING HOME.

How long in hospital or institution? 3 WEEKS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: ..... County: .....

City or town: WASHINGTON D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME: ABIGAIL WEED

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED.

6.(b) Name of husband or wife: FRANK W WEED

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): FEB 10TH 1880

8. AGE: Years: 68 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: PLATTSBURG NEW YORK (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: WILLIAM T HOWELL

13. Birthplace: MARYLAND

MOTHER — 14. Maiden name: SARAH CROSS

15. Birthplace: VIRGINIA.

16. Informant: MRS Robert C. ALOE

Address: 2623 - N. GREENBRIER ST. ARL. VA.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 12-20-48 (month) (day) (year)

Cemetery or crematory: ARLINGTON. NATIONAL

Location: VIRGINIA.

18. Funeral director: W.W. CHAMBERS CO

Address: 3072 M ST. N.W.

19. Dec. 16 19 48 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 16 1948 at 1:22 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 23 1948, to Dec. 16 1948 and that I last saw h[illegible] alive on Dec. 15 1948

Immediate cause of death	DURATION
Acute Myocarditis	
Due to Essential Hypertension	
Due to	
Other conditions Cerebral hemorrhage (old)	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Geo. C. Lowden M.D. M. D. or other

Address: 603 19th St. N.W. Date signed: 12-16-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46f

12691

Reg. Diat. No. 216

1. PLACE OF DEATH:
County MONTGOMERY CO., Md.
City or town Wash. 16, D.C. (SUMNER, MD)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months
Hospital, Institution, or street address where death occurred:
5009 Ft. Sumner Dr., Wash. 16, D.C.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Washington 16 D.C. (SUMNER, MD)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5009 Ft. Sumner Dr.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
NELLIE BLISS WHITAKER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife DICK RUFUS Whitaker
deceased 6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 25, 1879

8. AGE:

Years	Months	Days	If less than one day
69	1	29	hrs. min.

9. Birthplace Chicago, Ill.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business —

MOTHER FATHER
12. Name Williams Leighton Bliss
13. Birthplace Conn.
14. Maiden name Elizabeth Kerns
15. Birthplace Indiana

16. Informant RICHARD Whitaker
Address 5009 Ft. Sumner Dr. - Wash. 16, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 27, 1948 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Suitland, Md.
18 Funeral director S. H. Hines Co.
Address 2901 - 14th St. N.W. D.C.

19. 12-24 1948 (Date rec'd by registrar) WE Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1948, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1948 to Dec. 23 1948
and that I last saw h... alive on Dec. 23 1948

Immediate cause of death	DURATION
Carcinomatosis.	10 mo's.
Due to Adenocarcinoma of liver	12 mo's.
Due to	
Other conditions None —	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of liver with metastases — Date of op. Jan 6, '48
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W Decker, M.D. M. D. or other
Address 1725 - N St. N.W. (D.C.) Date signed 12-23-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12692

159

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr. +

Hospital, institution, or street address where death occurred: suburban Hospital
8600 Old Georgetown Rd. Bethesda Md.

How long in hospital or institution? 1 hr +

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8723 Ridge Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Anna Catherine Whiteman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, ~~married, widowed, or divorced~~
F	Wh	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11 25 P.M. 12-28-48

8. AGE: Years | Months | Days | If less than one day: 1 hr. 4 min.

9. Birthplace Suburban Hospital
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name Thomas Whiteman
13. Birthplace Washington D.C.

MOTHER — 14. Maiden name Anna Hudleson
15. Birthplace Washington D.C.

16. Informant Father (Thomas Whiteman
Address 8723 Ridge Rd, Bethesda Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 30, 1948 (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Washington, D.C.

18. Funeral director Wm Reuben Pumphrey Funeral Home.

Address Bethesda, Md.

19. 12-30 1948 W E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 1948, at 12 25 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from at birth 19 , to 19 and that I last saw h alive on Dec 28 19 48

Immediate cause of death Prematurity

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lee D Johnson M.D.
M. D. or other

Address 508 Eastern Ave Date signed 12/30/48

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C 12693

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH.

County Montgomery

City or town Germantown, Md. R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospitel, Institution, or street eddress where deeth occurred:

How long in hospitel or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville,

(If outside city or town limits, write RURAL and give nearest town)

Street No. Middle Lane.

(If rural, give LOCATION)

2.(a) If veteren, name wer

3. (a) FULL NAME Alice Mason Williams

3. (b) Social Security Number none

4. Sex	5. Color or rece	6.(a) Single, married, widowed, or divorced
Female	Colored	married

6.(b) Neme of husbend or wife Augustus Williams 6.(c) If elive, give ege yeers

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1923

8. AGE: Yeers	Months	Deys	If less then one dey
25	11	2	hrs. min.

9. Birthplece Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Neme Robert Jones

13. Birthplace Va

MOTHER 14. Maiden name Margaret Mason

15. Birthplace Md.

16. Informant Gladys Mason (aunt)

Address Blyds, md.

17. Burial (Burial, cremation, or removal. Which?) Dete thereof Dec. 19, 1948 (month) (day) (year)

Cemetery or cremetory Sugarland

Location Sugarland, Md.

18. Funerel director Robert L. Snowden

Address Rockville, Md

19. Dec 19 1948 Alfreda L. Cooke Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 19 48 at 4.30 P M

21. I CERTIFY thet deeth occurred on the date above steted; thet I ettended deceesed from Def. Med. Exam 19 to 19

end thet I lest saw h elive on 19

Immediate cause of death	DURATION
Acute Cardiac dilatation	1/2 hr.
Due to Chronic cardiac hypertrophy	2 mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Dete of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death wes due to externel ceuses, fill in the following:

Accident, suicide, or homicide Dete of

Where did injury occur? (City or town) (County) (State)

Injured et home, ferm, Industry, public piece (where?)

Msens of injury Injured et work?

23. SIGNATURE Frank J. Bouchard M.D. Def. Med. Exam M. D. or other

Address Gaithersburg Md Dete signed 12-18-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
DEC 22 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

12694

CERTIFICATE OF DEATH

Reg. Dist. No. 214

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Sandy Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
"Longmeade" Sandy Spring, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.: "Longmeade"
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: SARAH FORSYTH WILLSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George A. Willson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 18, 1867

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
81	0	6		

9. Birthplace: Penberton, New York
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Joshua Forsyth
13. Birthplace: N. J.

MOTHER
14. Maiden name: Elizabeth Earle
15. Birthplace: N. J.

16. Informant: Mr. George A. Willson
Address: "Longmeade" Sandy Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 26, 1948 (month) (day) (year)

Cemetery or crematory: Friend's Cemetery

Location: Sandy Spring, Md.

18. Funeral director: Warner E. Pumphrey, Inc.

Address: 8434 Georgia Ave. Silver Spring, Md.

19. Dec. 27 1948 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/24/ 1948 at 1230 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/1/ 1948 to 12/24/ 1948 and that I last saw h.... alive on 12/23/ 1948

Immediate cause of death	DURATION
Acute cardiac dilatation	1 day
Due to: Coronary Vascular disease with hypertension	3 yrs
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: J. M. Bird M. D. or Coroner

Address: Sandy Spring, Md. Date signed: 12/25/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12695

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 2-23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Virginia County

City or town Purcellville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Wilson, Mrs Elizabeth H

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1870

8. AGE: Years	Months	Days	If less than one day
78	5		hrs. min.

9. Birthplace Hamilton, Virginia
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER
12. Name (Information Not available)
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace

16. Informant Washington Sanitarium and Hospital Records
Address Takoma Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/21/48 (month) (day) (year)
Cemetery or crematory Purcellville
Location Purcellville, Virginia

18. Funeral director Joseph F. Birch's Sons
Address 3034 "M" St., N.W.

19. Dec 18 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1948 at 6:45 a.m. p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Dec. 18 1948 and that I last saw h[illegible] alive on Dec. 17. 1948

Immediate cause of death	DURATION
Congestive Cardiac Failure	Terminal
Due to Hypertension	20? Years
Due to Arteriosclerosis	Years
Other conditions Uremic State	One week

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert A. Hare M.D. M. D. or other

Address Takoma Park, Md. Date signed 12/18/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

421.4
131a

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Near Burtonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town in Burtonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Montgomery Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Thomas Wootten, Sr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Ida May Wootten

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) February 13, 1868

8. AGE: Years 80 | Months 10 | Days 4 | If less than one day ... hrs. ... min.

9. Birthplace Montpelier Pr. Geo. Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

FATHER 12. Name John Henry Wootten

13. Birthplace North Carolina - Wayne County

MOTHER 14. Maiden name Margaret Elizabeth Mitchell

15. Birthplace Anne Arundell Co. Maryland

16. Informant Franklin P. Wootten

Address Laurel, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 19 1948 (month) (day) (year)

Cemetery or crematory Union Cemetery

Location Burtonsville, Md.

18. Funeral director Ade With Ramsdell

Address Laurel, Maryland

19 Dec 18 1948 Gertrude B. Lawler

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17 1948 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-2-47 19... to 12/17 1948 and that I last saw h... alive on 12/16/48 19...

Immediate cause of death	DURATION
Endocarditis - Chronic	1 yr +
Intestinal Injury	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. B. Ramsdell M.D. or other

Address Laurel Date signed 12/17/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

12696

Reg. Dist. No. Y 14

1. PLACE OF DEATH:
County: Montgomery Co.
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10022 Dallas avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME ANNA VERONICA Wright

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Singhe

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): FEBRUARY 20 1882

8. AGE: Years	Months	Days	If less than one day
66	09	12	hrs. min.

9. Birthplace: OWEGO (Town, county, and state) NEW YORK

10. Usual occupation: Ret. Chaperon of Nurses
11. Industry or business: Gallinger Hosp. Wash. D.C.

FATHER
12. Name: Patrick Wright
13. Birthplace: IRELAND

MOTHER
14. Maiden name: MARY CONNELL
15. Birthplace: IRELAND

16. Informant: Mrs. Margaret M. Dobrowolskii
Address: 10022 Dallas Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 4 1948 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Washington, D.C.

18. Funeral director: The J. W. Hines Co.
Address: 2901-14th Street N. W. Washington, D.C.

19. Dec 2 1948 (Date rec'd by registrar) Josephine M. Schaeffle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2 1948, at 4 35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10 1948, to December 2 1948 and that I last saw h[illegible] alive on December 2 1948

	DURATION
Immediate cause of death: Coronary occlusion	4 Hrs
Due to: Hypertensive Heart Disease	15 years
Due to: Generalized arteriosclerosis	10 yrs
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Lennox K. Baughman M.D. M. D. or other
Address: 8252 Georgia Ave Date signed: 12/2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12697

131a

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, institution, or street address where death occurred:

Pine View Rest Home, River Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3000 Conn. Ave., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: THERESA MARCELLA YINGLING

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Clinton K. Yingling

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 3, 1858

8. AGE:

Years	Months	Days	If less than one day
90	1	1	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Dr. R. H. Thompson

13. Birthplace: Maryland

MOTHER

14. Maiden name: Theresa M. Gore

15. Birthplace: Maryland

16. Informant: Clinton K. Yingling

Address: 3000 Conn Av., N.W. D. C.

17. (Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)

Cemetery or crematory:

Location: Freedom, Maryland

18. Funeral director: S. H. Hines Co. Frederick Md

Address: 2901 -14th St., N.W. D.C.

19. (Date rec'd by registrar) 12/4/48 Registrar: W. E. Johns

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4, 1948 at 10.a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1940 to Dec 2 1948 and that I last saw h... alive on Dec 2 1948

Immediate cause of death: Cardio-Vascular Renal disease

DURATION

Due to: Cause

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 1801 - Eye St. N.W. Date signed: 12-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS A15 9-45-15M